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ORIGINAL DEPARTMENT.

LECTURE.

APTHOUS ULCERATION OF THE THROAT IN
TYPHOID FEVER.

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GENTLEMEN: At the debut of typhoid fever, the pharynx participates in the general congestion which affects all the mucous membranes, particularly those of the respiratory organs. And if the patient has been subject anteriorly to attacks of angina, this congestion, ordinarily latent or attracting but slight attention, may acquire considerable intensity and require constant attention on the part of the physician. In certain cases, the throat in general, including the tonsils, becomes covered with points of white exudation very much resembling thrush and with pultaceous, sebaceous and pseudo-membraneous deposits leading to more or less extensive ulceration.

These facts have been long known among clinicians, but receive little attention in classical works on the subject, being considered in a few lines among the pharyngeal complications of diphtheritis.

It would seem from their perusal that the throat determinations of the disease were very limited, whereas theoretic considerations alone would lead to an opposite opinion. The pharynx, exposed as it is to the entrance of all forms of contagious matter, should, on account of its structure, rich in lymphatics, show itself particularly favorable to the absorption of typhic germs in the same manner as the intestine with its closed follicles and its Peyer's patches.

In effect, the last Paris epidemic demonstrated that the typhoid processes may have an active determination towards the throat; the frequency of the throat accidents during the epidemic has led to the publication of several instructive memoirs on the subject.

We cannot, of course, as yet attempt a complete study of pharyngo-typhus, in its diverse forms, erythematous, pultaceous, ulcerated, diphtheritic, etc.

The angina of typhoid fever yet awaits its historian, as proven by the substantial *Revue critique* by Comby (*Progrès Medical*, 1883). But certain questions are at present elucidated, which are no less interesting at a practical than at a doctrinal point of view. Such is especially the case for the pharyngeal ulcerations and for a form of thrush (muguet) which appears in the throat.

At an anatomical point of view, the pharyngeal ulcerations of typhoid fever, were well studied long ago by Louis, and recently by Cornil and Ranvier, but they attracted little attention clinically until the last epidemic. After an observation published by Bouveret (*Ann. des Mal. de l'Oreille et du Larynx*), and two cases reported by M. Lecorché in his *Etudes Medicales* (1881), I myself presented a memoir on the subject to the *Société Med. des Hopitaux*, which provoked the relation of several analogous cases by my colleagues, MM. Feréol, Landouzy, and DuCastel.

Finally, the subject has been studied at every point of view in an excellent thesis by Derignac (*Des Determinations de la Fièvre Typhoïde sur le Pharynx et L'Isthme du Gosier*, 1883,) which is the more interesting as it contains some new ideas on general pathology.

The description given by these different authors are concordant, at least as regards the principal traits of the affection.

At the debut, the pharyngeal mucous membrane becomes of a deep red color and shining; then small ulcerations form but not in great number, round or oval in form and greyish in color. The borders of the ulceration are regular, and without apparent elevation above the surface of the mucous membrane, on which they are situated.

They are surrounded by a zone of congested mucous membrane, and I have compared them in my memoir to immense aphthæ.

The destructive process is generally superficial; the ulcer takes on a rose color, gradually fills up from the bottom, and heals, but not without leaving frequently a more or less marked cicatrix.

The ulceration rarely progresses at the same time in width and depth; when it does, it is covered with a greyish mass formed of necrosed tissues, the mucous membrane becoming detached and purulent sinuses form under it. It is without doubt, to a destructive process of this kind, passing as far as the larynx, that must be referred the cases of odema of the glottis and retro-pharyngeal abscess occurring during the course of typhoid fever.

These ulcerations are met with in all parts of the pharynx; but, in contradiction with the opinion of Murchison, the most common situation would appear to be on the tonsils or on the pillars of the fauces.

The subjective phenomena of this form of ulcerated sore throat vary in different cases. In some cases the dryness and pain in the throat, difficulty of deglutition, nasal tone of the voice, pain and ringing in the ears; in a word, all the habitual symptoms of angina, attract attention to the condition of the pharynx.

In other cases the morbid manifestations are wanting or little complained of. It may be easily understood how the angina can pass unperceived, when it supervenes at the culminating period of the fever, at a period when the patient is more or less delirious, and examination of the throat presents great difficulties.

Of all the characters, subjective and objective, of ulcerative angina, none present any real value for the diagnosis of typhoid fever, unless the existence of the malady is affirmed by the presence of other more marked symptoms. Derignac relates a case where typhoid angina was successively laid to the account of herpes, syphilis, and diphtheria.

Evidently, these errors of diagnosis would not occur if the ulcerative lesion, as was formerly believed, followed its course "*pari passu*" in the intestine and in the throat, and if the loss of substance in the closed follicles of the pharynx occurred as in Peyer's patches, during the second week of the malady.

But if such be usually the case, observations where ulcerations appeared very early in the disease are not wanting.

Diverse conclusive examples, reported by myself, Lecorché, and Derignac, prove that pharyngeal ulcerations may be met with during the first days, even before the appearance of the rose-colored spots.

Such an occurrence is of great importance at a doctrinal point of view. It leads, in effect, to the conclusion that the pharynx may be affected before the intestine by the germ of typhoid contagion.

This hypothesis appears the more admissible as it coincides with an observation we have frequently made. Many typhoid fever patients will tell you that eight or ten or fifteen days before the first manifestations of the disease, they suffered from sore throat or at least from a persistent sensation of dryness in this region. Would not this appear to be due to a slow germination of the infective material or microbe, preparing or leading to a general invasion of the economy?

And this form of slow incubation does not occur exclusively in the pharynx. It would seem that the same process occurs in the stomach, and that in many cases, where gastric troubles supervene two or three weeks before the other accidents of typhoid fever, the same interpretation might explain their occurrence. This is an hypothesis we will consider later, when treating exclusively of the gastric determinations of the disease.

This conception, that the pharyngeal mucous membrane, the tonsils particularly, may serve as a point of entrance for the infectious germs, has been brought forward in a very striking manner by Landouzy, in a clinical lecture on infectious amygdalitis. After insisting on the lymphoid structure of the tonsillar region, he demands if there is not at this point a soil already prepared for the reception, germination, and diffusion of certain infectious germs, which from point to point could in the end enter the lymphatic system, and finally be carried in the blood to all parts of the economy.

In any case, it is certain that this form of ulcerative angina is of a specific nature. The very complete histologic examinations of Doignac, leave no room for doubt in this respect. The pharyn-

geal alterations present, in effect, a striking analogy with those characteristic of typhoid fever. "Everywhere lesions of the lymph apparatus and of the vascular ramifications, such are the striking alterations." "It demonstrates, as Derignac observes, a common pathogenetic origin, the adulteration of the blood by a foreign element, without doubt of an infectious nature."

Whatever the pathogenic interpretation, a fact of high clinical interest remains established: that is the very early appearance of pharyngeal ulceration in certain cases of typhoid fever. It may easily be understood what difficulties the diagnosis presents in such cases. Without doubt, the concomitant phenomena are of great value to the practitioner, but even to the signs of generalized infection the most absolute confidence cannot be accorded. It would seem established by the researches of Kannenberg, Bouchard, and Landouzy, that there exist certain infectious processes affecting primarily the pharynx, which have no relation to any known infectious disease such as typhoid fever, scarlatina, or diphtheria. These authors have reported cases where patients presented, with a grave general condition, the symptoms of acute amygdalitis and infectious albuminuria. These observations, which might be provisionally termed cases of infectious amygdalitis, present an almost complete semeiologic similitude to the pharyngeal accidents of typhus.

Nevertheless, in dothin-enteritis the renal determinations supervene later, and the throat symptoms are ordinarily less marked; but it is the ulterior evolution of the pyrexia which alone will settle all the doubts of the physician.

If we have somewhat insisted on these delicate questions, it is to call attention to the fact that angina is not simply a local affection, as it is generally supposed to be; it is often the expression and frequently the most notable symptom of some disease affecting the entire organism. As regards the prognosis in laryngeal ulceration, either precocious or late-appearing, we have not as yet sufficient data to form an accurate opinion. In this respect, we will remain in comparative ignorance, until the subject has received the wide attention it merits, and each practitioner considers it a matter of duty to examine carefully the throat in all cases of typhoid fever.

Finally, it is hardly necessary to say that this form of angina will require special therapeutic intervention; the throat must, as far as possible, be kept clear of epithelial detritus, in order to facilitate deglutition and suppress a point open to the entrance of infectious germs.

This treatment is the more necessary, as the near neighborhood of such ulcerations to the eustachian tube has perhaps a large part in the production of certain forms of deafness, consecutive to typhoid fever.

But if the specific typhoid nature of the ulcerative form of angina cannot be denied, it is entirely different from a form of thrush (muguet) which appears in the throat during the course of typhoid fever, and which is a true complication and no more.

I have shown in a recent memoir (*Société Médicale des Hopitaux*, 16 Mai, 1883), from an analysis of fifty cases, where this complication occurred, that it did not sensibly modify the prognosis of the primary disease. The unfortunate consequences to which thrush might lead in hindering proper nutrition, are to be feared only when the veritable nature of the affection remains unrecognized, for no matter how tenacious it proves or how widely it spreads, we are too well provided with remedies against the *oidium albicans*, to dread any serious danger from its ravages.

This form of thrush is amended and disappears more or less rapidly under a very simple treatment by gargles containing borax or solutions of bicarbonate of soda.

It would seem also that the mortality is no higher in cases of typhoid fever complicated with thrush, proving that the well-known maxim that thrush is of fatal augury when appearing in adults, is not always well founded.

COMMUNICATIONS.

CLINICAL NOTES ON CYSTITIS AND SURGICAL KIDNEY.

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Few diseases are more common in some form or other than cystitis; indeed, in almost every affection of the urethra or kidneys we have at times a direct, at others a sympathetic affection of the bladder varying in intensity according as the primary trouble is more or less severe.

Again, we observe cystitis as the result of disease of the bladder itself primarily. Among the more ordinary causes of cystitis are wounds of the bladder, cold and wetting of the feet, catarrhal, rheumatic, or gouty diathesis, strictures, decomposition of urine, etc. It also sometimes develops during the course of acute fevers and may be induced in some subjects by the exhibition of the oil of turpentine and cantharides.

The pathological anatomy shows a thickening of the mucous membrane; in later stages of the muscularis also, and a well-marked injection with preponderant, often varicose widening of the veins in the walls of the bladder.

In pursuance of our intention to make these notes as practical as possible, we come directly to those points that may be of value to the practitioner.

Symptoms.—Sometimes the fever that is never wanting in well-developed cases of cystitis, precedes the local symptoms. There is unmistakable tenderness upon pressure on the abdomen, especially in the vicinity of the bladder. The pains radiate from there to the perineum and kidneys. The patient must urinate uncommonly often, and always with great pain; frequently after great straining he is able to press out only a few drops of a dark red urine, containing blood; this urine leaves on cooling a *slimy* sediment. This "tenesmus ad matulam" is analogous to the tenesmus in inflammation of the rectum, and is peculiarly characteristic of inflammation of the neck of the bladder, but can also occur when the muscular coat is affected, which then becomes more or less rigid like any other inflamed muscle; the bladder being full, presses upon the rectum and thus causes unnatural desire to defecate, the rectum being nevertheless entirely empty. The continued desire to urinate and impossibility to do so effectually (strangury) make the patient most miserable, causing him at times to lie in a state apathy of bathed in perspiration, at others to throw himself about unable to find comfort in any position. The cessation of this most distressing symptom occurs either very gradually or quite suddenly. In the first instance, we may expect a favorable turn; in the other, on the contrary, we may look for suppuration or gangrene. Then the fever, in spite of the relief from pain, does not abate; the pulse increasing in frequency, becomes continually smaller, the tongue dry, the thirst insatiable, hiccough, cardialgia, and vomiting are not seldom. The urine is then freely emptied, possessing much the same characteristics as before.

Prognosis.—Inflammation of the bladder is a serious disease, fatal when complicated with stone and thinning of the vesical walls.

Treatment.—At first copious topical blood-letting and antiphlogistic apparatus, with a due regard for the strength of the patient being our guide. Very long-lasting, so-called permanent baths, either of the whole body or at least hip-bath, and between these tepid cataplasms to the region of the bladder and perineum, are of great

value. The patient will not need to be told to lie still, as he will naturally find himself more comfortable when so doing: his diet must be low, but as he will have no appetite, there is little difficulty on that score. All his drinks, and these should be confined to milk, should be taken warm, and the entire body kept warm enough to invite perspiration. Dover's powder is a valuable adjuvant. If there is retention of urine that will not yield during this treatment, an elastic catheter may be introduced morning and evening, or oftener if necessary, but not left in the urethra, as it would certainly produce ulceration. If the cystitis is caused by an old stone it is our duty to try and relieve the cystitis as much as circumstances permit, and then operate by lithotomy—lithotripsy out of the question. If the inflammation of the bladder depends upon a blenorrhœa or stricture or disease of the prostata, we are compelled to treat both troubles at the same time, not forgetting the importance of the cystitis. In cases in which the cystitis is evidently due to rheumatic or gouty tendency, or to a suppressed eruption of the skin, strong skin irritants over the whole body are valuable; blisters in the regio hypogastrica—but better not by cantharides, in order to avoid any possibility of resorption.

In cases of cystitis caused by cantharides, I remove at once the offending cause, let the patient drink freely of water (soda water), bath, warm cataplasms to the abdomen and perineum, and if the pain is intense some morphia. Leeches are seldom necessary. In cases of cystitis brought about by administration of the oil of turpentine, I usually employ a solution of bromide of potash and water (3*℥*. to the 3), containing grs. xxx. of cannabis indica, and give of this a tablespoonful annually. Generally, but a few doses are required, the patient drinking warm linseed tea during treatment. In such cases the cystitis disappears promptly; but when due to other causes it may become chronic. In chronic inflammation of the bladder due to an acute cystitis mucosa, the fever gradually diminishes, and although the patient experiences from time to time, at regular intervals, formications and great pain in the region of the bladder, nevertheless the symptoms, although pointing unmistakably to cystitis, indicate a much more mild affection, but none the less tenacious on that account. The urine is murky, at times milky, at others colored yellowish brown, again reddish, containing blood. In severer cases it has an ammoniacal smell, but may in the first hours after being emptied go into acid fermentation. The chemical reaction varies, nevertheless

it is more alkaline the older and more severe the catarrh of the bladder is. The sediment contains besides pus and slime corpuscles (that is pushed off and disturbed or unripe epithelial cells) phosphate of ammonia magnesia. There is also often present, immediately after the urine has stagnated and before the sediment forms, a thin transparent coat floating upon it.

Treatment of Chronic Catarrh of the Bladder.—When the catarrh owes its existence to a foreign body in the bladder, this must be removed; the irritation necessarily caused by the operation to the mucous membrane of the bladder, appears to be of use in removing the catarrh and never causes a formidable cystitis. In like manner, the practitioner will have to regard all other ætiological relations—in one case a stricture, in another swelling of the prostate. In most cases it is of great import to remove the patient from the further injurious influences of cold and wet atmosphere. If the patient is able to move about, he should avoid the morning and evening air; regular diet should be ordered, and all excess avoided, care being taken to remove the urine entirely at regular intervals. But the patient must not press and strain to pass out the last drops of urine. This habit in cystitis would only keep up the irritation and undo all the good we may be otherwise accomplishing. As to doing it in health, that is equally pernicious, as the continual straining induces hypertrophy of the muscular walls of the bladder and of the prostata. Some cases of vessie à colonnes can be traced to this habit carried out over a period of years.

When an interruption in micturition occurs, the patient should be advised to change his position, as by so doing he will often facilitate the flow. If this does not succeed, a catheter may be employed, but must not be left in; being withdrawn as soon as used, the dangers of consecutive ulceration, followed by perforation, are thus avoided.

Among the medicaments for internal use astringents and resinous drugs are the most efficacious. In order to work directly upon the mucous membrane, injections into the bladder have been tried and with success.

Here, again, astringents are our most reliable agents; for example, as in blennorrhœa of the urethra, sulphate of zinc and nitrate of silver.

We have at the present writing experience enough to recognize, without doubt, the fact that such injections made with the requisite care prove themselves always very useful in chronic catarrh of the bladder, and are without especial danger.

We must take care that no air gets into the bladder, and further, that a too great quantity is not injected at one time (from two to six ounces, according to the capacity of the bladder), that the fluid is left in the bladder only so long as the patient bears it without pain, and finally that only a diluted solution is used, one part of sulphate of zinc, or sulpho-carbolate of zinc, or nitrate of silver to one hundred parts of water. Also injections of cold water only, when repeated often enough, are of value in the treatment of chronic catarrh of the bladder.

Cloquet and Civiale have used this extensively, even employing permanent irrigation by means of a double catheter, without ever having observed the least bad consequence. In some cases of local catarrh of the bladder, usually near the neck, Ricord used to introduce the nitrate of silver in substance (by means of a holder contrived for the purpose) and touch the diseased portion. After the cauterization, he used injections of water in order to wash away any superfluity of caustic that might result from the solution of nitrate of silver when in contact with the secretions of the urethra and bladder.

If an abscess forms in the wall of the bladder, as soon as our diagnosis is made we should puncture with the trocar, and give free outlet to the pus. Paralysis of the bladder in consequence of cystitis is rare and should be regarded as much a symptom of a general affection as a disease per se, and treated accordingly; that is, by making the probability of a central trouble our basis, and using besides local astringents and tonic applications, strychnia, nux vomica, alternating or combining with phosphorus internally.

Surgical Kidney.—This is a pathological condition of the kidney regarded by some writers as directly due to stricture, that is, without any pathological connecting-link between the stricture of the urethra and the affection of the kidney. During a long experience in the treatment of urinary diseases, I have not unfrequently examined the parts after death as regards pathological anatomical conditions, and have found my cases to fall naturally into three groups: 1. Those of stricture, the affection not extending beyond the entrance, or just inside the bladder. 2. Those in which the cystitis was well marked throughout the entire bladder or a large portion of it. 3. Those in which there was surgical kidney with cystitis. Never have I observed surgical kidney with stricture alone, the bladder being free from cystitis; that a sympathetic affection may developed in the kidneys, especially after opera-

tion for stricture of the urethra, is not denied. The complication of surgical kidney is of the gravest import, especially as it sets in in cases of long-standing, which have already begun to tell upon the general organism, and for this reason we owe most of our knowledge of the subject to post-mortem investigations. Its onset is usually very gradual and insidious, and the patient soon complains of intense pain in the renal region accompanied by rigors, oppression in breathing, jactations alternating with semi-coma. The urine will be found on examination to contain now a large proportion of pus due to the affection of the parenchyma of the kidney, which came in due process from the inflammation of the mucous membrane of the ureters and bladder. There is now great pain in the abdomen, owing to the affection of the peritoneum in the region of the kidneys. The secretion of urine becomes exceedingly scant. There is usually formation of small centres of pus in the kidney especially in the pelvis; this is easily recognized in the urine. High fever and rapid septic-uræmic symptoms verging toward typhoid hurry the patient to his end.

The treatment must be decidedly antiphlogistic—blood letting, cupping, cold applications in the neighborhood of the kidneys, both of which are usually affected (generally one more than the other), strong diet with purgatives, best of calomel. As a drink, barley-water or linseed-water.

If the fever begins to lessen and perspiration returns with a freer secretion of urine, we must look well to the causal factor: remove retention of urine by the catheter, treat the stricture, if there is one, by bougies, and endeavor to remove any renal calculi by ordering soda water, Grand Grille, Carlsbad. The annoying desire to urinate almost constantly demands relief by opium and hip baths, as do the panis narcotic cataplasms on the region of the kidneys and general warm baths; the sinking condition of the patient's strength, strong but mild diet, iron, and quinine.

The post-mortem appearances are: increased size of the kidney, dark red or purplish appearance; the capsule is injected. In further development of this hyperæmia are found in the interstitial tissue of the kidney, yellowish spots which later assume the character of pus cells, and small abscesses forming in the rind or tubulous substance; these small abscesses finally unite and make a considerable deposit of pus.

These are the post-mortal appearances in surgical kidney. We have only given a general outline of them, sufficient, however, for the practi-

tioner, who will be more interested in presenting a post-mortal issue than in going into microscopical histology.

GLIMPSES OF SEVENTEENTH CENTURY MEDICINE AND MEDICAL MEN.

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II.

In a former number of the REPORTER (April 7), I furnished some extracts from the introduction to the "Practice of Physick of Sylvius," which give a rather animated picture of the medical life and manners of the period, and the method of exchanging professional courtesies and dissent from contemporaneous opinion. I have now to present extracts from the body of the work, which illustrate, in a graphic way, the condition of the medical art at the period named, and is especially interesting in novel points of etiology and pathology, while its therapeutic resources will invite many comparisons with the measures in vogue at the present day.

The work of Sylvius was composed of three books, occupying the same number of volumes.

Under the title of "The Distribution of the Work," a clear idea is given of the direction and scope of the author's teaching.

1. "*In our delivering a Practice of Physick for our Auditor's sake and profit compendiously, and indeed not much unlike the Platerian Method we will first propose those Diseases, which are more single, seeing the knowledge of Compound and Complicated Ones is easier opened if the former be known.*"

2. "*And seeing Man's Health is manifested by the perfection of all his Functions, and his Sickness by the hurt and deficiency thereof: we judg it fit to treat of the Diseases in order, that are obvious to Physicians in practice according to the diversity of the Functions in Man that are hurt, because they either constitute, produce or follow them.*"

The first topic is entitled, "*Of First Deprav'd.*" "We therefore assign the first place among Natural Functions to Thirst, because the first Natural Passion of Man newly Born is to Thirst, and by sucking Milk out of the Breast assuages his Thirst."

"I take Thirst augmented," our author remarks, "to be deduced for the most part from too sharp Choler, carried down into the small Gut, and there so raising an effervescency with the Juice of the Pancreas, flowing thither, that thence are elevated Salt Vapors, but not bitter, to the Ventricle (or Stomach) and Gullet, and there produce a sense of Drought." * * Another cause, also, of

Thirst augmented, is a *Salt Humor* distilling from the Head to the Gullet, and there producing a perception of Drought and Thirst; and then either falling thence, also, down to the Ventricle, or drawing forth Matter for Salt Vapors in the small Gut, by which, in like manner, a great Thirst is stirred up." Hot air, salt food, exercise, anger, great terror, prolonged watches, costiveness, and notable evacuations are also spoken of as causes of thirst; but there is no mention of fever as a cause.

Chapter 2 is devoted to "*Hunger Deprav'd.*" He says, "*Hunger* is call'd the Appetite of Meats, as *Thirst* is of Drinks. * * I judg the chief Cause of Natural Hunger to be the remainders of Food fermented in the Ventricle, and there staying, and still more and more fermented by part of the Spittle adhering to them, being continually swallow'd down, and at length raising a somewhat sour and grateful Vapor, which pleasingly affects the upper Orifice of the Ventricle, and so produces Hunger." Again: "Most commonly the Cause of *Hunger deprav'd*, that rages among Women, is to be drawn from the suppression of their Monthly Courses; for these standing about the Womb, and so more or less corrupted; and then after being mixt with the whole Mass of Blood, and infecting it, all the Mass thereof is vitiated and deprav'd. From which, as the Cachexy is produc'd, so both Spittle, the Juice of the *Pancreas*, and the other Humors in the Body are bred vitious, and together with the most, and sometimes all the Functions Hunger is also deprav'd." * *

"*Hunger increas'd* is to be cur'd, by giving those things which temperate, destroy and amend the Acid Juice in the Body, and do prevent its increase. *Lixiviat Salts*, both fix'd and volatil, do destroy most powerfully this Acid Juice; as other things abounding with either of them, Coral, Pearls, Crab's-Eyes, Chalk, Blood-Stone, Amber, the filings of Steel, and such like."

"*Hunger, gradually Diminish'd or Abolish'd*, will be cur'd by Medicines that correct and carry out the Viscous Phlegmatic Humor."

The following is used "When there is need to purge:

"R. Fetid pills,	3 ss.
Pills of cochia,	3j.
Catholic extract,	3 ss.
Oil of cloves,	ii drops.

"M.—Make them into fifteen Pills to be guilded, or done over with Powder of Licorish or Cinamon. Let the sick take five, or more, of these Pills, as he is observ'd to be easie or hard to be purged."

Chapter iv. is denominatd, "*Of the taking in of Food hindred.*" He says: "It suffices not Man

to desire Meat and Drink, unless he take the same in at his Mouth, and lessen the more solid parts by chewing, and thence swallow it through the Gullet into the Stomach." Among hindering causes he enumerates "*Convulsion* of the Muscles of the Temples," and "*Palsie* of the same"; "*jaw out of joint*," "*a cross wound*," "*Spasmus Trismus*," etc.

Chapter vi. treats "*Of the Retention of Food hindred in the Stomach.*" "It sufficeth not," he says, "that Food is taken into the Mouth, and swallowed down through the Throat, unless the same stay and be retained in the Stomach a convenient space, and so long, till it be sufficiently fermented there. This required stay and retention is hindred * * by the fault of other Humors that were before in the Body, if they incite the Stomach by their acrimony." "The salt sharpness," he claims, "such as is in Sea and digg'd Salt, and most salted things, is wonderfully corrected with unslak't Lime made of burnt Flints or Shells, not to be fear'd any more by any prudent Physician, and to be most happily us'd in most Diseases in the form of a Lie." "The Ferment of the Stomach is Deficient, when there is not enough of it in the defect of Spittle, or in a continual Spitting; or it's carri'd another way, by a continual drinking, whereby it is driven forward to the Guts. Continual Spitting is to be disaccustom'd by degrees. For this follows the ill manner and custom. And it is good to contain the Tongue quiet in the Mouth, seeing by it often moving the effusion of too plentiful Spittle is promoted."

"The Fermentation of Food Abolish't or Diminish't because of too much of it taken in, may be Cur'd often with Hunger only, or Food sparingly taken for a space." "The same may be sooner obtain'd by using Medicines that promote Fermentation, such chiefly are Sour and lixiviat salt things alter'd, and more or less volatiliz'd by a volatile spirit. Hereto belongs spirit of salt dulcifi'd by iterated cohobation with Spirit of Wine; also Salt of Tartar made volatil with Spirit of Wine. Salt of Amber, of Urine, Hartshorn; and Salt Armoniac, its Spirit or volatil Salt, etc."

Chapter xi., "*Of the Vitious Effervescency of Cholera, and the Juice of the Pancreas; together with Phlegm continually rais'd in the small or thin Gut.*"

"Cholera and the Juice of the Pancreas do not only flow together into the small Gut, when the Food fermented is driven forward out of the Stomach to the Guts; but continually, and so also at that time are they carri'd thither, when no Food is taken in or carri'd down to the Guts, and of necessity they stir up an effervescency in their Concourse there, for the somewhat contrary disposition of their Parts, mild

and friendly to Nature in Health, that is, as long as both are well dispos'd and temper'd; but vitious and hurtful when either, or both of them is intemperate and over-sharp." Again: "I take it, that in that Conflux of these two humors the more fluid part of Phlegm adhering to the sides of the small Gut is dissolv'd, and that the same being join'd with the most part of Cholera, and the Juice of the Pancreas increasing, pierces into the Lacteal Veins to the Heart. * * * This Three-fold Humor rising from Cholera, the Juice of the Pancreas, and the Phlegm of Spittle, and hasting with the Lympha to the Heart, seem to me to give the natural Consistency and Coagulation to the Blood * * howsoever vitiated."

Chapter xiv: "Of various Pains of the Guts." "The Sick use commonly to endure all kinds of Pains, one while burning with a great Heat, another time Chill with a grievous Coldness; again fixt, and as it were, boring the Loins, or, moreover, pricking with wandering Thrusts repeting: anon distending or beating the Loins, or only pressing them with the Sense of Weight, or Burning, Corroding, Tearing, or troublesome, either with a continual or interrupted Pulsation, or wonderfully writhing and contorting any other way, scarce to be explain'd by the Sick, or by Physicians."

The cause of pain is thus set forth: "We take it that a Chill Pain, troublesom with grievous Coldness, takes its original from the Juice of the Pancreas very acid and sharp, raising an effervescency with Cholera less fat or little, and also overwhelm'd with Phlegmatic Humors, as we observe that Spirit of Vitriol mixt with any Volatil Salt, but not oily, raises an effervescency, coupled with a notable chilness and coldness, only sensible." "A Boaring and Fixt Pain may be Cur'd, by correcting and tempering both the Acid Acrimonie of the Juice of the Pancreas, and also the viscosness of Phlegm accompanying; which is chiefly performed by Aromatic Gums, Galbanum, Sagapen, Bdellium, Ammoniac, Apoponax, Mustich, Myrrh, etc., as also by any volatil salt, and chiefly oily."

(To be Continued.)

HOSPITAL REPORTS.

NEW YORK HOSPITAL.

CLINIC OF PROF. WILLIAM H. DRAPER.

Reported by W. H. SEELYE, A. M., M. D.

Catarrhal Pneumonia.

Patient's name is M. H. A native of Ireland; age, thirty-six; single. No history of venereal disease. His family history is negative as regards pulmonary disease. He has been a moderate

drinker of malt liquors. At one time he had a severe attack of rheumatic fever. While employed as a brakeman on the Erie railroad, four years ago, he had his left leg crushed, and it was amputated three or four inches above the ankle. Before this he was in good health, and has been since until two or three weeks ago, when he began to be troubled with malaise, headache, coughing, with slight mucous expectoration tinged with blood, and some fever. Eight or nine days ago he says he noticed a few streaks of blood in the sputa. Four days ago he had a chill followed by violent fever, and pain over the left side of his chest, and for this trouble he came to the hospital. Bronchitis and pulmonary congestion had already existed for two or three weeks before this attack.

Gentlemen, it is evident from this history that the acute affection of the chest here is a pneumonia of the left lung, which grew out of a bronchial catarrh which had lasted for two or three weeks. This is the regular history of many cases of pneumonia, which are catarrhal in origin, and which grow out of a bronchitis caused by some exposure. This variety of pneumonia is distinguished from other pneumonias by the epithet of "catarrhal pneumonia." In croupous pneumonia the patient is seized suddenly with a chill, fever, pain in the side, coughing, expectoration of bloody sputa, or a hemorrhage. The disease takes its start in the air-cells of the lungs, and does not extend to them from the bronchial tubes as happens in catarrhal pneumonia.

This man's history since he came in is that yesterday he had a chill, and his temperature at 10.35 p. m. was 102.6°. It reached its lowest point at 3.30 this morning when it was at 101.4°. At 1 p. m. to-day it was 103°. His pulse last evening was 118, and this morning and since 104 per minute. His respiration was 32 per minute and it has remained there. These are the vital signs which existed at the time of and since his entrance. They are very important in the history of every case of pneumonia, because in this disease especially there are certain limits to the pulse, respiration, and temperature, beyond which large experience and observation have shown that it is not safe to pass, and these are called safety limits. So by carefully watching these vital symptoms, you are able to follow the progress of the disease, and to know at any time from the beginning to the end whether the patient is within the limits of safety or not. The safety limits for this disease are found to be, for the respiration, 40 per minute; pulse, 120; and temperature, 104°. I do not mean to say, however, that there may not often be recovery when these limits have been passed; but most cases do not recover. Nor is recovery sure below these limits, but danger is not to be so much feared in these cases. In very old people, these vital signs are not found to be so good a guide as to safety and danger. But in young persons and healthy adults you may feel pretty safe in the majority of cases if all the vital symptoms are within the limits.

This fever and these acute symptoms may last five, ten, or even twelve days, but those cases in which the fever runs for twelve days are extremely rare. In the great majority of cases the crisis occurs on the seventh or eighth day. In children it often comes on the fourth or fifth day,

and it sometimes does in adults also, but we do not expect it until the seventh or eighth day. The peculiarity of the crisis is a quick subsidence of the fever and the other acute symptoms. The temperature may suddenly fall from 104° to the normal within a few hours. At night the patient may be suffering from the most active and dangerous symptoms, with a very high temperature, and the next morning he may be comparatively well with all the acute symptoms gone, and recovery is now rapid. This sudden cessation of fever is the striking fact which gave rise to the opinion that pneumonia is not merely an inflammation of the lung, but a constitutional disease, of which the pulmonary lesion is only a constant symptom. For while the portion of the lung involved is absolutely consolidated, and the inflammatory process going on there is at its height, the fever suddenly subsides, although that which was formerly supposed to be the cause of the fever is still there. But after the sudden subsidence of the fever, the diseased lung gradually returns to its normal state; and this is probably brought about chiefly by an absorption of the inflammatory products in the lung. Another reason why pneumonia is now regarded as an essential fever, is that its termination in a crisis is like the termination of the striking examples of essential fevers. Thus in typhus fever there may be a temperature of 104° , with wild delirium and most acute symptoms when the crisis comes, and the fever suddenly ends, the mind clears up, and the patient becomes perfectly rational, the pulse is normal, and the patient is practically well. Pneumonia, typhus fever, and erysipelas, are all therefore examples of an essential febrile process which is not secondary to any local lesion, but independent of it, and the local lesion is only an incident in the progress of the general disorder.

Now, a word in regard to another point in regard to this man's history, which is more or less directly connected with his present disease. I refer to the attack of rheumatism involving all the joints, which he says he had two years ago. Croupous pneumonia is a disease which we occasionally see complicating rheumatism, though pleurisy and pericarditis are more common complications. In regard to the catarrhal form of pneumonia, I think from my experience that it is especially liable to occur in persons who are inclined to rheumatic affections. But a very large proportion of the cases of rheumatism which come into this hospital are men who have been addicted to the use of malt and spirituous liquors. So I am inclined to believe that there is a remote relation between pneumonia and the rheumatic habit of constitution not only, but there is certainly some relation also between the history of pneumonia and the habit of indulgence in alcoholic liquors. And those who are accustomed to the use of wine and beer to excess are much more liable to this disease than those who are not. Moreover, the same susceptibility to this disease is transmitted to the children of these parents.

Our attention will next be directed to the physical examination of this patient. And in making the physical examination, your attention should first be directed to the vital signs, that is, to the condition of the temperature, respiration, and pulse. And before taking the temperature, deter-

mine at the beginning where you will take it throughout, whether in the axilla or the mouth or in some other locality, so that there will be no confusion in your records from taking it now in one place and then in another. If you choose the axilla, you must be careful to see that the thermometer is well-covered by the tissues. If you have a thin bony patient, with an axilla so open that it is impossible to close it about the thermometer, you had better not use the axilla here; for you might about as well put the thermometer in the bed and expect to get an accurate record as by this means. A perfectly-closed cavity is necessary for accuracy, hence in children and thin persons you should use the mouth, rectum, or vagina. The temperatures of this man have been taken in the axilla, and they will continue to be axillary throughout.

After taking the temperature, your next duty is to count the respirations. And here again you may make an error unless you use a little tact. For the nervousness and disturbance caused by the excitement of the doctor's visit may produce a variation in the respiration at first. Therefore, you should not take your record immediately on your entrance into the patient's presence, but wait until after he has become thoroughly quieted and at ease. This same nervous excitement may also cause similar variations in the pulse.

Having taken a record of all the vital signs, your next duty is to examine the chest. And this you should do from day to day, unless there is some contraindication, in order that you may know the course of the pathological changes. It is not necessary to make the examination more than once a day, unless the vital signs become so suddenly changed as to excite your suspicions of some new complication. You must also take the patient's condition into consideration, and if he is weak, and the examination wearies or bothers him too much, it should be less frequently made. You must remember that the examination is not medicinal, as a rule; though I have sometimes known it to do good, because the patient thought that this was a part of the therapeutical machinery which was expected to assist recovery, and his faith in the skill of the doctor was a powerful factor in hastening on this result. But that is a sort of faith which I hope none of you will ever encourage. In fact, I think that the faith of the patient in the doctor should not need encouragement, but that it should rather be depreciated.

Inspection.—You observe, in the first place, that the dyspnoea is not very considerable, and the patient lies flat on his back, and he is not obliged to be propped up for the sake of breathing with comfort. The number of his respirations is seldom less than 32 per minute, but this is not a very considerable number when you remember that his pulse is 118. If the respirations were 32, while the pulse was only 60 or 70, we might think more of it. But here it is no more than we have reason to expect from the degree of fever which he has. The abdominal respiration is a little more prominent than usual, but it is not labored. You will also notice that the superficial veins of the abdomen and chest are somewhat prominent; and this suggests some interference with the portal circulation. It may be due to cirrhosis. The abdomen also appears to be enlarged slightly, and this may be due to a cirrhosis of the liver.

Palpation.—I find that the lower portion of the right lung expands a little more freely than the left. There is not much difference in the upper portion, on the two sides. The apex beat can not be felt.

Percussion.—The upper and lower margins of the liver dullness are normal, so there is not any considerable atrophy of the liver. But there may be an interstitial disease, and atrophy even, with enlargement of the organ, the disease not yet having arrived at the contracting stage. There is dullness on percussion over the apex of the left lung posteriorly. In the lower portion of the right chest the pulmonary resonance is better than on the left. The area of cardiac dullness is normal.

Auscultation.—The heart-sounds are natural and very good in quality. The respiratory murmur over the front portion of the right lung is modified by some hoarse ronchi in the larger tubes. In the lower portion of the left lung the respiratory murmur is exaggerated, but higher up and in the axillary line I can hear a distinct bronchial respiration, and this is still more distinct from behind; it is a true bronchophony.

It is now evident from this physical examination that the pneumonia in this case is situated in the upper portion of the left lung, and chiefly in its posterior part. This is a less common location of pneumonia than in the lower lobe of the lung, and especially of the right lung. Before this case reaches the day of crisis, the whole of the diseased lung may be consolidated, and to-morrow, even, we may get dullness all over the anterior portion of the left side of the chest. There is a slight trace of albumen in his urine. But this is of little importance, because this is a common symptom in pneumonia and other fevers. In fact, the essential fevers are reckoned among the causes of a temporary albuminuria, and we usually find it in the early stages of scarlet fever and measles in small quantities.

It is a fortunate circumstance that in some diseases our knowledge of their regular course enables us to give a pretty definite answer to the question as to the probable duration of the disease. And so it is in this case. It is well to let the patient understand that the disease has a natural course to run, and that you can do nothing to shorten it. And then he will not reproach you because he does not get better from day to day, and you will have, therefore, a better control over him.

We now come to the question of treatment. And the first thing to do is to put the patient to bed, and then keep him there; and thus you will secure what is of primary importance in the treatment of all acute diseases, namely, absolute rest. This fact is not recognized by physicians as much as it should be in the treatment of fevers. But in surgery there is no question of its importance, as, for instance, in acute inflammations after injury of a part. But in the treatment of acute diseases the question of rest often does not receive the attention which it deserves from the physician. I believe that in many cases of phthisis the patients are forced into taking violent exercise where their chances of recovery would have been much greater if they had kept still, and they would have been better off without the exercise.

I think that a great deal more ought to be said about this matter both by clinical teachers and by practical treatises on the treatment of disease. And I urge you all to read a classical book on this subject, and one which will long remain classical; I refer to Hilton's book on "Rest and Pain."

The fact is, in many cases rest is all that is needed. You may, in a case of pneumonia, let the pulse go up to 120, and the temperature to 104°, and if the patient is well nursed and kept quiet in bed, he may go on to the end of the disease and recover without taking a drop of medicine. You cannot cut short the disease by medicine. At one time it was thought that this could be accomplished by bleeding the patient; but bleeding will not do it. Then it was thought that it could be done by tartarized antimony; but this is no longer used for this purpose. Then calomel was tried; and some practitioners to this day believe that given in large doses at the beginning it will stop the course of the disease. But I believe that when the patient has once started with a pneumonia, there is no way of aborting it, but it will run its course to the end. But, you will say, we must do something. Well, there is something for you to do. For it is not the fact that every case of pneumonia occurs in a perfectly healthy subject, who is blessed with a strong heart and a good digestion. You may be obliged to give stimulants for a flagging heart, or opium for the relief of pain. But you are not by these means doing anything to cure the disease; you are merely meeting emergencies as they arise. You meet pain with opium, and a weak and irregular pulse with wine, and exhaustion and indigestion with quinine and tonics, and a too high temperature with cold spongings of the surface. I can remember the time when a great deal more than this was done, not only in the way of administering stimulants, but the patient was often wrapped up in poultices, or swathed in cotton, or made to wear an oil-silk jacket, and caused to sweat profusely from beginning to end. But now I think that the oil-silk jacket, and the cotton, and the poultices, except occasionally for the relief of local pain, are abandoned in this hospital; though I believe that in private practice the jacket and the poultices are still used by some.

This patient has been taking nothing but quinine and a little brandy, because his pulse is feeble. But he is doing very well, and by the time you come here again next week, you will probably find him convalescent.

MEDICAL SOCIETIES.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

Stated meeting, Thursday, June 7, 1883. The President, R. A. Cleemann, M. D., in the chair.

Dr. Fred C. Sheppard exhibited the uterus and appendages removed *post mortem* from a case of

Interstitial or Tubo-uterine Fotation,
and read the following report:

Through the courtesy of Dr. George S. Hull, of Chambersburg, Pa., I am enabled to present, this evening, the *post mortem* specimens of one of the

rarer forms of extra-uterine pregnancy. The history of the case is given in such a clear and complete form by Dr. Hull, that I will read it in his own words:

"(April 11, 1883.) A few days ago it fell to my lot, as Coroner, to hold an inquest on a colored woman who had died suddenly. Vomiting followed by death, together with a history of family troubles, led her friends to suspect her husband of poisoning her."

"About three a. m., pains had set in in the left inguinal region, accompanied by severe vomiting; I could not learn whether the pain preceded the vomiting or vice versa. A physician was sent for; he did not go but sent three $\frac{1}{4}$ grain morphia powders. She took one every hour, seemed easier, and the vomiting ceased. At noon, becoming very weak, the doctor was again sent for, responded in person, and found the patient pulseless at the radials; he ascertained that she had been constipated for about a week, and made a diagnosis of obstruction of the bowels; he gave five compound cathartic pills, and ordered an enema. In an hour the patient was dead."

"Autopsy. Peritoneum inflamed (recent—no pus); stomach empty save the pills, which were liquefied; intestines normal. About two quarts of clotted blood were found in the abdominal cavity. The womb was ruptured, a small circular rent in the fundus about the left cornu."

"The uterus was removed and the rent enlarged; a fetus of about three months with membranes entire was found. The placenta seemed attached at the point of rupture."

"The pregnancy seemed to be interstitial, the tube being involved. The lower half or two-thirds of the uterus was much hypertrophied and contained two or three teaspoonfuls of mucus, which could be pressed out at the os uteri. There was no communication between the pus-cavity and the cavity containing the fetus. The uterus was not adherent to the other organs."

A sketch by Dr. Hull shows the uterus inclined to the right side, the fetal sac occupying very nearly the normal position of the fundus, and the point of rupture a little to the left of the line of the umbilicus.

"It occurred to my mind that the rupture was spontaneous, causing the vomiting and pain of the night; however, the woman had eaten of sauer-kraut for supper, and it might have caused the vomiting, and that in turn the rupture. The morphia allayed the symptoms for a time, but the hemorrhage was slowly going on, and peritonitis setting in; the former predominating, death took place from loss of blood. She was the mother of one child, and was to all appearances in good health up to the time of the accident."

An examination of this very interesting specimen shows an enlarged womb with a dilated cavity, the walls of which are hypertrophied to a thickness of seven-eighths of an inch; lining this cavity is a structure which appears to be a true uterine decidua; the os is small, with an irregular stellate outline, and is perfectly patulous; the cervix is partially absorbed. The right ovary is small and flattened; the left of about normal size; at the point of entrance of the left Fallopian tube is a large intra-mural cavity, which contained the fetus; the outer wall of this cavity is

exceedingly thinned, and presents ragged edges at the point where rupture took place; to the inner wall are attached some remnants of the placenta; no communication can be detected between the fetal cyst and the uterine cavity. The fetus is apparently of from three to four months, and is presented with the membranes unbroken.

To cases of this class the terms interstitial, tubo-uterine, utero-interstitial, and parietal, have been applied. Dr. Parry, in his work on *Extra-Uterine Pregnancy*, classifies them under the head of "tubo-uterine, or those in which the germ is arrested in that portion of the tube which passes through the uterus." They are very rare. An analysis by Hecker (quoted by Parry), shows twenty-six cases out of two hundred and twenty-two, and Parry in his analysis of five hundred cases of extra-uterine pregnancy, finds but thirty-one of the tubo-uterine variety; but two hundred and thirty of his cases are grouped under the general head of doubtful. Mr. Alban Doran, (*Obstet. Trans.*, vol. xxiv., 1882, p. 234) has been able to find but six specimens in all London, though he states that "we see a goodly array of the more frequent tubal form in almost every museum." I will not occupy your time this evening by referring to the question of pathology or of diagnosis, as both points cover the entire ground of extra-uterine pregnancy, and will be discussed in a future paper.

The proper treatment to adopt in these cases is, however, a point of great interest, and merits notice. A ruptured extra-uterine fetal cyst may cause death instantaneously, as in the case of the English actress mentioned by Dr. Chabazian (*Obstet. Trans.*, 1882, p. 157). "She was taking an ice in the Bois de Boulogne, she fell down suddenly, and she was dead." Poisoning being suspected, an autopsy was performed. No trace of poison was detected, but the ruptured pouch of an extra-uterine foetation showed the cause of death. In this case, of course, there was no time for surgical interference; but in many, as in the one reported this evening, an appreciable interval elapses between the first symptoms and the fatal issue. The diagnosis being made, what would be the proper course to pursue? Unquestionably, laparotomy. An exploratory incision would at once reveal the true condition of affairs, and the surgeon could either incise the cyst, turn out the contents, ligate the bleeding points, suture the edges to those of the abdominal wound, and establish drainage; or, if thought better, remove entire the uterus and its appendages. Either plan would offer a very fair prospect of recovery, while if left without surgical aid the patient would be doomed to inevitable death.

A number of points of interest present themselves in the study of this interesting case, but the limits of a paper of this character forbid us taking them up. I might merely call your attention to the large quantity of blood; Dr. Hull states, about two quarts exuded from a comparatively trifling rent. This fact has been repeatedly commented upon by other observers. Dr. Parry states that some of the most severe hemorrhages occur when the orifices are very small, and cites a number of instances in which from several pounds to two and a half gallons of blood have been found in the abdominal cavity after rupture of extra-uterine cysts.

In conclusion, let me recall to your mind Dr. Hodge's case. His patient went to the eighth month, labor was brought on by dilating the os uteri, and the child delivered by rupturing the septum between the uterine cavity and the fetal sac; the child was delivered by the natural passages. The child lived two hours, and the mother made a complete recovery.

Dr. B. F. Baer had examined the specimens, and felt a doubt of its having been of the usual form of uterine tubo-gestation. That form is the rarest, and is considered the least dangerous, because not so liable to rupture, in consequence of having the muscular tissue of the uterine wall to strengthen it. In Dr. Hodge's case, the septum of uterine tissue between the uterine cavity and the fetal sac was so thin that it could be scratched through with the finger. As the case reported by Dr. Sheppard terminated by rupture about the third or fourth month, it resembles a tubal in that particular. The question of operative interference is very interesting. In this case, as ten hours elapsed between the accident and death, an operation would be justifiable if the diagnosis could have been established.

Dr. Alfred Whelen remarked that Miss Neilson lived ten hours after the first shock of her illness, and the published report of the autopsy stated the cause of the death to have been rupture of varicose ovarian veins.

Dr. Sheppard, in closing the discussion, remarked that Parry classes all of this type of cases as tubo-uterine. The sac in this case was undoubtedly in the uterine wall, as the specimen shows. He had not been able to pass a bristle from the uterus into the Fallopian tube. As regards the possibility of the spontaneous stopping of the hemorrhage as a reason for postponing the operation, he would not consider it advisable to wait, for even when the laceration is very small, as in this case, the hemorrhage may, and probably will, be excessive; this hemorrhage is the cause of death in most, if not all, of the cases, and the only chance for the patient is in stopping the hemorrhage and removing the already effused blood. If the diagnosis can be made, laparotomy is justifiable, and would be the only resort. In the report by the French physician to the Obstetrical Society, no name is given, the patient is simply mentioned as an English actress.

Knotted Umbilical Cord.

Dr. Cleemann exhibited for Dr. John A. Hunter an umbilical cord tied into a complete single knot. There was no difference in size of any portion of the cord and there had been no interference with the nutrition of the fetus. Dr. Hunter had not been present at the birth of the child, but had come in soon afterwards, and in tying the cord and removing the placenta he noticed the knot. In a case reported by Dr. Wm. F. Jenks to this Society, a failure of the fetal heart was noticed by auscultation; the child died, in utero and the knot in the cord was suggested as a probable cause of the death of the fetus. Such a knot as is seen in Dr. Hunter's case might be formed during parturition if a loop of the cord was around the child's neck and it was loosened and the body allowed to pass through it in the process of extraction.

Dr. Montgomery thought that such a knot, if

existing in utero, might develop a murmur that could be discovered by auscultation.

Acute Hydramnios.

Dr. E. E. Montgomery remarked that although dropsy of the amnion is a quite frequent condition, that above named is exceedingly rare. For this reason he has felt that the following case was worthy of record:

June 4, 1883, he saw Mrs. P. in consultation with Dr. Chase. She was pregnant for the fourth time. In the one preceding this she had miscarried. Her last menstruation occurred December 10, 1882. In her former pregnancies she had been quite small, carrying the fetus low down. This time the abdomen was larger than formerly at the same period, but she continued without any special discomfort until one week ago, when, without any assignable cause, the abdomen began rapidly to increase in size, and continued to do so. The increase has been attended by pain, tenderness, difficulty in breathing, entire loss of sleep for three days, loss of appetite, and scanty flow of urine. She has been obliged to maintain a sitting posture, as lying down greatly increased the difficulty of breathing. They examined the urine, but found it free from albumen. The abdomen was distended more than we would expect to find it at a full term. The tumor projected well forward and upward and a little more prominent to the right. It was perfectly regular in outline. The skin of the abdomen was smooth, tense, and glistening, and could not be pinched up over the tumor. It was quite tender to pressure. Short-waved fluctuation was distinct over the whole surface, percussion was dull; a slight tympanitic resonance could be determined in both inguinal regions. No part of the fetus could be distinguished by abdominal palpitation. In fact, all the external signs were those of an ovarian tumor. They imagined they heard the heart-sounds, but so indistinctly as to be uncertain. She said she had felt the fetal movement for several days very slightly. Per vaginam the cervix was found dilated, the os open so as to admit two fingers to enter it. The vertex of a fetus was felt presenting, and, singularly, was but slightly movable.

Considering the rapid enlargement in a few days, the extreme discomfort of the woman, as well as the imperiled circulation and the extreme improbability of the woman or fetus surviving until the latter had reached a viable age, they concluded the best course was to induce premature labor, and from the urgent need of relief, to cause it by rupturing the membranes. This he did, and on the evening of the same day a still-born fetus was extracted. The upper part of the abdomen still continued almost as large as before. Examination per vaginam revealed the membranes of a second child. The rupture of these was followed by a gush and discharge of an enormous quantity of water. The second fetus and the placenta were soon extracted. The latter was single with two cords. One cord appeared to have only a membranous attachment, but closer examination showed that it had been torn off from the base of the other cord. The quantity of liquor amni was so great that it soaked through folded quilts, mattress, floor, and ceiling, and dripped upon the floor of the room below. The uterus contracted firmly and the patient was at once re-

lived. The children were both males, and well developed for the sixth month; the second child lived a few minutes.

The fixed position of a fetus in the os in these cases has been given by McClintock as a sure indication of a plural pregnancy, but I must confess that this did not occur to me at the time, though I was unable to account for the anomaly. The existence of a single placenta in twin pregnancies is said always to be accompanied by children of like sex; this theory is here confirmed as far as is possible by one case. As to the cause of the condition authorities greatly differ. Gervis, in *St. Thomas Hospital Reports*, brings the causes under three heads:

1. Cases due to inflammatory conditions of the amnion.
2. Cases where the decidua has been found diseased and hypertrophied, but the amnion healthy. This will cause effusion in the amnion by transudation owing to a disturbed circulation. In these cases the fetus suffers and may atrophy.
3. It may arise from some maternal blood dyscrasia of uncertain nature, but evidencing itself by the same condition recurring in successive pregnancies in the same patient.

Puerperal albuminuria may be the cause, and comes under this head.

Simpson says disease of the placenta is likely to recur in the same individual. Savage asserts that an oedematous condition of the placenta is present in all cases of hydraunios. McClintock found a morbid condition of the placenta in every case. Mercier always attributed it to inflammation of the amnion. Others have ascribed it to obstruction of the fetal portal circulation, or in the cord giving rise to transudation into the sac from the surface of the cord. Hydrannios greatly endangers the life of the fetus. Of forty-three cases collected by McClintock, in which children were born where this condition existed, twenty were still-born, sixteen of these had ceased to live for some days or weeks before labor, eleven of those born living died in a few days. Of thirty-three cases, four mothers died, showing a high maternal mortality.

In this patient the success of the treatment was greater than expected. As the distension had been so rapid, they feared loss of power in the walls of the uterus, and a consequent long first stage and liability to hemorrhage. It becomes an important question to decide whether they were justified in undertaking so promptly the induction of premature labor, but they felt that the probability of the death of the fetus and the danger to the mother certainly in this case justified the procedure.

Dr. B. F. Baer read the following

Supplement to the paper on the Effect of the Operation for the Restoration of the Lacerated Cervix Uteri on Fertility, Confirmatory of the Views there Advanced.

He there expressed the conviction, based upon his own experience, that sterility did not follow as a result of the operation, as had been asserted, but because the pathological conditions which almost constantly exist with the laceration were frequently not relieved, and this applied especially to the old cases. He there made this statement: "The longer the time which has elapsed between

the occurrence of the injury and its repair (pregnancy being absent during this time), the greater and more permanent will be the changes in and about the uterus, which almost necessarily result in a continuance of the sterility after the cervix has been restored;" and he also said that if five years or more had expired between the occurrence of the injury and its repair, sterility would be likely to remain. In support of this, he reported twenty-seven cases, of which number thirteen had been sterile from six to sixteen years. Of this number, not one has become pregnant since the operation; but of the eight cases in which pregnancy had occurred within two to five years previous to the operation, he reported four that had become pregnant, and he now adds two more.

CASE 5. Mrs. X., aged 32 years, mother of three children, youngest three years of age, complained of severe metrorrhagia every three weeks, and profuse leucorrhœa in the intervals, together with a dull aching pain in the lumbar region and pelvis and a sharp spasmodic pain in the bladder, which caused an almost constant desire to micturate. She had lost weight, was anæmic and nervous, and had so many obscure aches and pains that the doctor took refuge in writing the words "general hyperæsthesia from nervous exhaustion." Physical examination showed the perineum to be lacerated to the external sphincter ani muscle, but not through it. The cervix uteri was torn bilaterally, to the vaginal attachment, but not much hypertrophied. The body of the uterus was only slightly enlarged, but its cavity was relaxed and granular. On January 30, 1881, after four weeks' preparatory treatment, he operated on the cervix and secured a good result. He was made anxious on the second day after the operation by a rise of the temperature to 102°C, which, however, subsided to the normal by the next day. This rise he ascribed to the use of the curette just before operating, which he now thinks ought not to have been used. This is the only instance in which he has observed a perceptible increase of temperature after this operation. This patient objected so strongly to the use of the catheter that he allowed her to pass her urine spontaneously. Since union was perfect here, he allowed his next patient to do the same, with a like good result, and this has been his custom ever since. It was his purpose to restore the perineum, but she was so much benefited that she refused to permit it, and returned to her home in Michigan. A communication received a few weeks since informed him that she was spontaneously delivered at term six months ago.

CASE 6. Mrs. M., has had three children at term and one miscarriage, the latter two years previous to February, 1878, at which time she first consulted him. She complained of a dragging pain in the back from the sacrum to the nape of the neck, with menorrhagia and leucorrhœa. The neck and body of the uterus were hypertrophied, soft, and tender, and the former was badly torn on both sides; the mucous membrane was everted and abraded; sound entered four inches. February 17, 1880, he operated for the lacerated cervix; union was immediate. In his case-book October 25, 1881: "This patient has been in excellent health since the operation; whereas, I had pursued the ordinary local treatment at intervals

during two years before it, with only temporary improvement." She is now in the fifth month of gestation. This makes seventy-five per cent. of

pregnancies following the operation of the eight cases of this class.

W. H. H. GITHENS, Secretary.

EDITORIAL DEPARTMENT.

PERISCOPE.

Antisepsis in Ovariectomy and Battey's Operation—Eighteen Consecutive Cases—All Successful.

Dr. Robert Battey, of Rome, Ga., contributes an article on this subject to the August number of the *Virginia Med. Mo.*, which concludes as follows:

"It will be seen from the brief history given, that these cases were for the most part favorable ones, but not without complications. They were not selected at all, but each case was operated upon as presented.

"The antisepsis was not strictly Listerian. It consisted in the use of the spray by a very superior German silver instrument, long used by Mr. Lawson Tait, of Birmingham, England, who was kind enough to offer it to me on my visit to him in 1881, that I might 'bring it to America just to show how not to do it,' as he pleasantly remarked. I find this atomizer an admirable apparatus; it throws an ample spray to a long distance, and it will maintain it for two hours. I use a two-and-a-half per cent. solution of carbolic acid, and the same for instruments and sponges, which are kept constantly immersed. Carbolyzed silk is alone used for ligatures and sutures. Precaution is observed that only clean and pure hands touch the abdomen. The greatest care is used in the purification of instruments and sponges. The wound is dressed with carbolic cerate surmounted by a mass of loose raw cotton and flannel bandage.

"It is a notable fact that since my last visit to Europe, the success of these operations in my hands has markedly improved. Why is this? In looking the ground over, I find myself at a loss to attribute the gain to any one thing. Without entering upon the discussion of the vexed question of bacterian influences it is a well-settled fact that a good, pure atmosphere is a most valuable aid to successful surgery. An observation of thirty-five years in this mountain region of Georgia, has fully satisfied me that wounds of all kinds, without antiseptics, heal with a promptness and absence of complications which I have nowhere else observed, either in America or in Europe.

"It has been my habit, and still is, to lay aside the so-called 'dignity of the profession,' when occasion arises, and to take hold with my own hands and assist in nursing any and every way that the safety of my patient may require.

"Experience and skill in this operation certainly should have high rank in estimating the chances of success. To neither of these, however, can the sudden and marked alteration in my results be attributed. I am myself inclined to look

first to the observance of *extreme cleanliness* in hands, instruments, sponges, bedding, furniture, etc.; second, to the discarding of the *écraseur* as an instrument full of crevices for the lodgment of filth, very difficult to clean, and full of danger to the patient; thirdly, the use of hemostatic forceps, which materially shortened the time of operating, save blood, and lessen the shock.

"Of the spray and the use of carbolic acid in general, whilst I think it has been pretty clearly shown by Keith, Bantock, and Tait, that neither is essential to the highest success, and when strong may even prove poisonous to patient and surgeon, I feel assured that weaker solutions do no harm, and think they may serve to guard the patient against any slight imperfections in the details of cleansing. Quite sure am I that my own results, with the acid and the spray, are now as good as I could desire—let those who can get the same results without these aids do so. For myself, I am content to hold them as valuable assistants until their utter uselessness has been more conclusively shown.

"My experience has been uniform upon one point, namely: When I have yielded to the solicitation of a patient, and operated at her distant home, leaving her in the hands of her family physician, the convalescence has been unduly slow, and not satisfactory. In a few cases, they have gone beneath the sod when I could but feel that they might have been saved.

"The friends of a patient are by no means the best nurses for an ovariectomy case. Whilst in England I was assured that no operator who had any character to lose would venture to stake it upon an operation to be done under such disadvantages. They all require their cases to come to them, and put them into the hands of their trained nurses.

Tumor of the Parotid Space.

The following case is reported in the *N. Y. Med. Jour.*, July 28, 1883:

A woman, forty-five years old, from the Province of Kwong-sai, was admitted to the Medical Missionary Society's Hospital, Canton, with a tumor of the right side of the face, extending from above the ear to the collar-bone, and from the corner of the mouth to the neck behind the ear. It was almost as large as her head, and had been growing for eighteen years, until now the weight made it very burdensome, and she was anxious to have it removed. About four years ago she went to a hospital at Hankow, on the upper Yangtze, when it was about half as large; but for some reason the operation was not performed. The outer and lower part of the tumor

was ulcerated, and discharged a thin sanious pus. The tumor was excised on the 10th of August, Dr. Joseph Thomson assisting. The skin was loosely



FIG. 1.

attached and easily dissected: but there were several enlarged veins, from which some blood was lost. The attachments in the parotid space were deep and strong, requiring careful dissection; but they did not involve the sheath of the vessels. The arteries and veins at the base of the tumor, constituting its blood supply, were, of course, large, and, with all possible precautions and as much rapidity of dissection as was admis-



FIG. 2.

sible, the loss of blood was great. On the completion of the operation, the patient was very

much prostrated from shock and loss of blood. The application of hot bottles, stimulants, and the elevation of the lower extremities, brought about reaction. In a few days convalescence was decided, and the wound healed favorably. In two weeks she was able to walk about, and cicatrization was almost complete. The wood-cuts, taken from photographs, show the appearance of the woman with the tumor and after its removal. The weight of the tumor was four pounds. It was a glandular tumor, the irregularity of the surface indicating different lobes of which it was composed.

An Experimental Research on the Utero-Placental Circulation.

Dr. J. P. Pyle presented as a graduating thesis at the last annual commencement of the University of Pennsylvania (*Med. Times*, July 28, 1883,) a memoir with the above title. It is desired, as soon as practicable, to publish the paper entire, as it seems a scientific contribution of decided value. The conclusions the author deduces are formulated as follows:

"Nineteen experiments were made with ultramarine blue. In each instance the blue, which had been introduced into the circulation, was found widely distributed in the maternal organs. The total number of fetuses obtained from these animals was sixty-one. Of these, forty-six gave positive results, i. e., the fetal tissues were impregnated with blue granules in varying quantities. Only fifteen of these fetuses gave negative results.

"Of the placenta only fifteen were examined, thirteen of these showing blue granules, the remaining two giving negative results.

"Of the thirteen umbilical cords examined, eight gave positive and five negative evidence. I regret that, owing to circumstances beyond my control, the remainder of the cords and placenta were not examined.

"It is also seen that ten experiments were made with septic poisonings with the object to study the transition of bacteria from the mother to the fetus. The maternal tissues were in every case impregnated with bacteria. Of the thirty-nine fetuses examined, in every one identical bacteria were discovered. Eight of the placenta gave positive results, as well as seven of the umbilical cords examined.

"The control experiments, two in number, made with the object to determine whether or not the bacteria were of an accidental occurrence, gave negative evidence. It is true that putrefactive bacteria do occur in animals after the lapse of a certain time after death, and this I observed in the blood from the heart of the animal which was examined eighteen hours after death. But even here the fetuses were free of them. Moreover, it can be seen from my experiments that the examinations were made immediately after death, or within a few hours, and that only bacteria pertaining to septicæmia (micrococci) were seen, and not the organs of putrefaction, which are dumb-bell-shaped and rod-like. The few negative results are certainly of no significance in contrast with the many positive observations, especially in view of the difficulty in making the examinations.

"The observation in the human being, which I had the exceptional opportunity to make, I regard of still greater importance than all the experiments combined. As elsewhere described, I have observed that the bacteridian disease of the mother is transmitted to the fetus. The examination of the fetus, which was removed by Caesarian section, was made one hour after the death of the mother. In this case, also, the bacteria in the blood and tissues of the fetus could surely not be accidental.

"I think that Cohnheim's theory of the migration of white blood-corpuscles, which has lately been proven by himself to be a mere passive process of filtration through the blood-vessel walls, is a fair analogy to what we may find in the transmission of solid particles through the attenuated utero-placental walls."

How Can We Obtain the Best Eyesight and Hearing.

Dr. Leartus Connor contributes an article with this title to the *Cincinnati Med. News*, July, 1883, which thus concludes:

To sum up what we have suggested, in plain propositions, the best eyesight and hearing can be obtained and maintained by—

1. By acting as if the eyesight and hearing were of more importance than any other thing on earth.

2. By having every child's eyes and ears carefully examined by an expert before it is given specific tasks to perform, calling for the full exercise of healthy eyes. If the eye or ear be found defective, then by grading the tasks according to the nature of the defect.

3. By never using the eye or the ear when such use causes pain in either organ or in the head.

4. By never using the eye when it is imperfectly supplied with good blood, as before breakfast, when utterly exhausted, after a severe illness, etc.

5. By never using the eyes for close work in an imperfect light, as in early morning or evening twilight, by a very distant and weak light, far from the window on a dark day, etc.

6. By utterly avoiding the use of tobacco and alcohol, except for medicinal purposes.

7. By always cherishing a cheerful habit or thought and feeling toward all persons and all events.

8. By avoiding all such injuries to the ears as result from slapping, pulling, and very loud and sudden noises.

9. By keeping out of the external ear all things smaller than the forefinger, or stiffer than a towel or handkerchief.

10. By keeping out of the ear all oils, all soaps, all cold water, and everything else recommended by sympathizing but mistaken friends; especially never apply a poultice to the ear for the relief of pain. Dry heat will do all that moist heat can to relieve, and will be free from the danger of absolutely destroying the membrana tympani.

11. All running ears must be cured at the earliest possible moment, at the peril not only of the hearing, but that also of the life.

12. By heeding the warning given by redness of the eyelids and of the white of the eye, by

pain in or about the eyes or ears, by the continuance of indistinct vision for any considerable time, or of imperfect hearing, by the continuance of frontal headache after usual remedies have failed to relieve it.

13. By regarding the eyes and ears as simply a part of a very complex system of apparatuses, the best health of all being absolutely needful for the best health of each.

14. By remembering that we do not see with the eye or hear with the ear, but with the brain. Hence, after the brain is exhausted, it is impossible to really see or hear. Hence, the utter absurdity as well as the perniciousness of any endeavor to see or hear after the brain has become exhausted. Especially is this true of young and growing brains. Here, too, it is needful to remember that the normal brain continues to grow until about the age of forty.

Disorders of Urinary Apparatus.

The following occurs in the course of the address on Surgery at the late meeting of the British Medical Association, by Mr. Reginald Harrison:

If we take the obstructive disorders of the urinary apparatus, and inquire what feature of them is most detrimental to the associated parts, the answer undoubtedly will be the misdirection of the muscular force that is thereby entailed. How can we explain the structural alterations which take place behind the obstructed point, and which manifest themselves in different ways, except as the results of urinary retention and retrograding pressure? How frequently do we find, in cases of stricture or enlarged prostate, that the whole of the apparatus behind the primary constriction consists of little less than dilated sacculi and tubes. Is not this distinct evidence of the back-pressure going on, though it may be imperceptible, from the moment that impediment arises to the escape of urine from the bladder? The more we study animal mechanics, either in their physiological or pathological application, the more can we appreciate the truism that force is never lost. If it is not permitted to act for good, it must be productive of evil; if it is not exerted towards the legitimate fulfilment of a normal act, it must inevitably exercise a corresponding pressure in an abnormal direction. Whenever I see, in the *post mortem* room, an ordinary specimen of dilated kidney, tortuous ureter, or sacculated bladder, associated with an enlarged prostate, or a stricture, the expression of "misdirected force" almost involuntarily escapes from me.

The Pathology of Phthisis.

In the address on Pathology at the same meeting, by Dr. T. Henry Green, the following occurs:

The teaching of pathology, respecting phthisis, justifies, I think, the following three propositions.

1. The morbid processes which lead to phthisical consolidation of the lung are inflammatory in their nature; by which it is simply meant to imply that they owe their origin to some kind of injury of the pulmonary tissues. 2. Phthisical consolidation of the lung differs from most other forms of pneumonic consolidation, inasmuch as it exercises an injurious influence upon the adjacent

and distinct pulmonary tissues, and thus tends to spread. To this infective property, which varies considerably in different cases and under different circumstances, the progressive character of phthisical consolidation is largely due. 3. The infectiveness of phthisical consolidation is, in all probability, due to changes in the inflammatory products, for the occurrence of which the presence of organisms is a necessary condition. Koch's investigations seem, therefore, to supply the element that is wanting to establish the truth of our pathology as far as it has gone—they discover the organisms, the existence of which had been foretold. But they do much more than this; they appear to prove that the organisms are specific. This, if true, is undoubtedly a most important additional link in the still incomplete pathological chain; and our previous knowledge of the pathology of phthisis is, as it seems to me, rather in favor of than against its acceptance.

REVIEWS AND BOOK NOTICES.

NOTES ON CURRENT MEDICAL LITERATURE.

—"Acute Articular Rheumatism" is the title of a reprint from the *Columbus Medical Journal*, July, 1883, of an article by Dr. E. O. Bardwell, of Emporium, Pa., which is a very interesting and readable article on a subject in which we are all deeply interested.

—The *Therapeutic Gazette* has sent us, in the form of a reprint from its July issue, the results of its collective investigation of diphtheria. It is a valuable pamphlet.

—"Microscopy in the University of Michigan" is the title of an article by Dr. C. H. Stowell in the *Microscope* for June, 1883. It comes to us as a reprint.

—A paper that will give much comfort to the general practitioner is entitled "Hints on the Treatment of Some Parasitic Skin Diseases," by George H. Rohé, M. D. It comes to us as a reprint from the *Medical Record*, June 2, 1883.

—"On a Hitherto Undescribed Malformation of the Naso-Pharynx," by John N. Mackenzie, M. D., of Baltimore, is the title of a paper that will appear in the next issue of the *Quarterly Compendium of Medical Science*.

—The same author sends us a reprint of an article on "Nasal Cough," from the *American Journal of the Medical Sciences* for July, 1883.

—"Surgical Treatment of Wounds," by R. H. Day, M. D. Reprinted from the *New Orleans Medical and Surgical Journal*, for June, 1883. This paper was read before the Louisiana State Medical Society.

—Acne is sometimes a most distressing and obstinate complaint. Hence the reprint from the *Medical Chronicle* (May, 1883), by Dr. George H. Rohé, on the treatment of it, should find many grateful readers.

—The same author sends us a practically valuable reprint from the *Medical News*, June 23, 1883, on "Pemphigus and the Diseases Liable to be Mistaken for It."

—We have already made an extract from Dr. John Morris's article on "Hydrops Chorii," which now comes to us as a reprint from the *Medical Chronicle*, July, 1883.

—To our antiquarian readers, the reprint from the *American Antiquarian* entitled "A Part of the Navajos Mythology," by Mr. W. Matthews, will prove interesting.

—A case of "Primary Monomania," by C. B. Burr, M. D., is the title of a reprint from the *American Journal of the Medical Sciences* for July, 1883.

—"Godey's Lady's Book," for September, contains even more than its usual amount of interesting matter. Its presidential gallery this month furnishes the picture of ex-President Hayes.

BOOK NOTICES.

Anatomy, Descriptive and Surgical. By Henry Gray, F. R. S. A new American, from the tenth English edition. Philadelphia, Henry C. Lea's Son & Co., 1883.

It is scarcely necessary to do more than mention the issue of a new edition of "*Gray's Anatomy*." It is thoroughly familiar to all physicians and students, who regard it as the work on anatomy in the English language. To this edition has been added "Landmarks, Medical and Surgical," by Luther Holden, F. R. C. S. Mr. T. Holmes presents an introduction on General Anatomy and Development; the drawings are by Dr. H. V. Carter, late Demonstrator of Anatomy at St. George's Hospital, London; while the American editor, the distinguished teacher of anatomy, Dr. W. W. Keen, has added many points that help much towards making this book a work that is absolutely essential to every physician and to every student of medicine. We must also commend the publishers for the handsome manner in which they have bound this standard work, which renders it not only useful, but exceedingly ornamental.

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THE QUESTION OF FOOD IN OBSTETRIC AND GYNECOLOGICAL PRACTICE.

This is the title of an address by Dr. Graily Hewitt at the opening of the section of Obstetric Medicine at the late meeting of the British Medical Association.

The author's well-known ability, and the novelty of what he had to say, render his address worthy of wide publicity.

To summarize, Dr. Hewitt considers that insufficient diet, particularly a deficiency of meat, has much to do with the diseases of women. He says:

"With very few exceptions, and those exceptions only tending to prove the rule, it is, I hold, impossible to find patients suffering from chronic uterine disease, who have not undergone, at some former period, what may be termed a starvation process; and careful inquiry generally elicits the fact that the quantitative deficiency in the diet extended over a considerable period. In many cases, the patients are found to be still under the influence of a deficiency in this direction, and to be 'eating,' as the expression is, 'next to nothing.'

"The period of life during which quantitative deficiencies in the dietary are most common, is the two or three years immediately following the arrival of puberty. The girl is at school probably, her appetite is bad, or the food is not palatable, or is deficient in important particulars, or, as I have found in some cases, she eats little in order to keep thin; the strength fails, the appetite diminishes, and a habit of taking little is formed—particularly little animal food is taken. Three or four years of the most critical stages of life are thus passed, a time at which the body should be growing fast, and to maintain this growth in adequate vigor, large supplies of nutritious material are required; instead of which, the supply is far below the normal standard. The result is a general impairment of vigor and of vital action. On the generative organs, the effect is, as I have observed in numbers of cases, most decidedly injurious; and the effect, in most instances, is of this kind, that the tissues of the uterus lose their

normal firm, healthy consistence. The further result is, that the pelvic organs, as a whole, but particularly the uterus, undergo a subsidence in the pelvis; the uterus becomes liable to change of shape, and other alterations, more or less marked, in different cases. Slight exertions, slight accidents, or even moderate exercise, are, under these circumstances, liable to act most prejudicially on the softened and weakened contents of the pelvis.

"This is a faithful description of what I have observed to occur in very many cases. I refrain from pursuing the further history of patients so affected, as not falling within the scope of these remarks.

"There are few observations bearing on the subject now under discussion which can be quoted from published works. Professor Voit (*Untersuchung der Kost*, Munich, 1877,) mentions an interesting fact. In a public institution, a home for girls, on which he reports, the diet included an average quantity of 170 grains of nitrogen only; the girls appeared healthy, but their muscles were found to be weak, and menstruation was found to be delayed in many cases until the sixteenth or seventeenth year.

"Parkes states that when the nitrogen is reduced to from 70 to 100 grains daily, the body gradually lessens in activity, and passes into a more or less adynamic condition, which predisposes to the attacks of all the specific diseases, especially malarious affections, typhus and pneumonia, etc.

"We all know that health and a good appetite usually go together. But it seems to be too frequently the case that, when the appetite is absent, such absence is taken as a matter of course, and receives no notice. It results from what has been stated, that absence of appetite may lead to most serious results. It is not immediately dangerous, but it is the first step possibly in the downward course. A continuously bad appetite constitutes a grave condition, and should be seriously regarded.

"If it be a rigorously-proved fact that the human body is dependent for its existence, in a state of vigor, on an adequate and regular supply of

food, it behooves us to take all possible opportunities of enforcing this great principle; and in making it known as a great and universally applicable measure and precaution in the prevention of disease."

PRESIDENTIAL ADDRESS—BRITISH MEDICAL ASSOCIATION.

The President of the British Medical Association at its late meeting, Dr. A. T. H. Waters, delivered an address which is peculiarly worthy of attentive consideration.

After briefly reviewing the past history of the Association, the speaker very wisely devoted the major portion of his address to the glorious future which he predicted for [the profession and the Association.

He sensibly told his hearers that they must not rest satisfied with what had been accomplished, that they must not contentedly and lazily gaze back into the past, but, rather, realizing from what has been accomplished how very much yet remains to be done, work steadily and unitedly onwards; for, as the speaker says, "the temple of medicine will never be crowned"—the more we learn, the more will be demonstrated to us the amount yet to be learned, and so on it will ever be.

Touching upon the value of the collective investigation of disease, Dr. Waters said:

"And here I must express the great satisfaction with which, in common, I am sure, with every member of the Association, I have seen the establishment of this Collective Investigation Committee, how strongly I feel that it is capable of accomplishing most valuable work, and how much I think we are indebted to Professor Humphry for initiating the movement. Doubtless, a large part of the work of the Committee will consist in collating facts with reference to specific disease: but there is one line of inquiry which, I trust, will receive from it a share of attention. I mean the consideration of the points of difference between functional disturbances and the early symptoms of organic affections. How difficult is it sometimes to say, when some slight symptom pre-

sents itself, and when no objective signs of organic disease can be discovered, whether that symptom indicates incipient structural change or mere functional disarrangement! Upon the right appreciation of the phenomenon, however, the safety of the patient may depend; for, although we stand almost powerless to arrest the course of confirmed structural changes, there can be no doubt that, could we recognize the earliest steps in these changes, could we see clearly the points of departure from normal conditions in various chronic and hitherto incurable maladies, we might do much to check these alterations of structure, and prevent the further progress of the disease."

The relations of micro-organisms to disease the speaker considers as the greatest question that can occupy the mind of the pathologist and the physician.

After pointing out in many ways the great questions now before the profession, the speaker thus closed with an allusion to vivisection:

"But if the results to which I have alluded, and the advances which I have ventured to foreshadow, are to be realized, if medicine is to be raised from the region of empiricism, and to be placed on a higher scientific level, and if we in this country are to take our part in the researches by which the great problems now awaiting solution are to be determined, then must all unwise legislative restriction on the work of the physiologist and pathologist be withdrawn; then must all measures which fetter the action of the original investigator be removed; and I trust that, by the labors of the Society which has been established for the cultivation of medicine by original research, a more enlightened public opinion will be formed, which will aid in bringing about these results.

"Medicine must more and more proceed on the lines of exact observation and careful scientific inquiry; and in connection with this it is satisfactory to know that one of our great guilds is about to devote a portion of its means to the encouragement of work such as I have referred to; and I trust that our own Society will be able yearly to devote larger sums than at present to a like cause."

THE HOLY WELL AT MECCA.

We all recognize the great potency of impure water in the production of disease, and we endeavor to guard against its baneful influence. In this connection the following reliable information concerning the water of Hagar's well at Mecca will prove interesting, if not practically valuable.

Some water from this well was sent to Dr. Frankland for analysis, and he makes the following report:

"The water is slightly turbid and has a saline taste. One hundred thousand parts of it contain in solution the very large proportion of 828.24 parts of solid matter, of which a considerable amount is organic and of animal origin. The water also contains an enormous quantity of nitrates—the usual product of the decomposition of animal excreta. The previous animal contamination, calculated from the proportion of nitrogen as nitrates and nitrites, shows that the liquid supplying this well contains in a given volume nearly six times as much animal matter as is found in the same volume of strong London sewage. This conclusion is confirmed by the presence of a very large proportion of common salt, one of the chief constituents of urine. The suspended matter in the water consists chiefly of dead bacteria."

Mr. Zohrab, late English Consul at Jeddah, gives the following particulars, which will account for this pollution:

"The city of Mecca, lying in a basin, contains a permanent population of about 40,000 souls, and annually during the Hadj (pilgrimage) from 100,000 to 150,000 pilgrims, who become residents for periods varying from one week to three months, crowd into it. This vast influx of strangers finds accommodation where it can; the well-to-do rent rooms, the poor live in the streets. The houses in Mecca are generally built in flats to accommodate pilgrims; each flat is provided with one or two badly-constructed latrines, and there are from six to twelve of these in each house. These latrines empty themselves into pits dug outside the houses. When these get filled they are emptied into other pits, which are made in the streets or any convenient spot, and then covered

over with earth. For the poor, latrines on the same principle are made in and outside the town, and the same method of emptying them is employed. This system of burying foul matter in every direction has been pursued for centuries; it is not, therefore, surprising that the ground in and around Mecca is surcharged with excrementitious matter, which rains (these are frequent in Mecca) carry by filtration into the wells. Hagar's well is not a spring, but its water is supplied by filtration—that is, by rain-water passing down through an overlying mass of foul matter. But there is yet another cause for the pollution of Hagar's well—this is the thousands of pilgrims, diseased or sound, who daily wash beside it, the water they use naturally finding its way back into the well."

Dr. Frankland considers that this well furnishes a most excellent place for the propagation of cholera germs or poison, and the fact that this water is sent throughout Mahomedan countries, would account in great measure for its spread.

Certainly, hygiene must be looked upon as a lost art, among the Mahomedans.

AN IMPORTANT MEDICO-LEGAL POINT.

A case recently tried in Michigan has given rise to a discussion as to whether arsenic, if injected into the stomach and bowels after death, will become disseminated throughout the various organs and tissues of the body. One would, at first blush, naturally assume the negative; but Drs. Victor C. Vaughan and James H. Dawson have made some experiments, the results of which they communicate to the *Journal of the American Medical Association*, August 4, 1883, and which seem to support the affirmative. They injected arsenic into the stomach and rectum of a large musk-rat, and of a human being, dead between two and three days; in each case, after an interval of twenty-five days, arsenic was found in appreciable quantity in all the organs.

When we remember that arsenic is so often used as an embalming liquid, we can appreciate the importance of these experiments, which are

corroborated by similar results in the hands of Professor Kedzie, of the Michigan Agricultural College.

NOTES AND COMMENTS.

Tuberculosis in Fowls.

Dr. Ribbert, of Bonn, has had recently the opportunity of making quite extensive observations on this subject, owing to the prevalence of the disease among fowls in and near Cologne, and he contributes his labors to the *Deutsch. Med. Woch.* In the intestines, beneath the serous coat, he found nodules, which contained great numbers of bacilli.

Perhaps the most interesting fact that comes out of Dr. Ribbert's work consists in the observed relation of the bacilli to the blood-vessels, particularly of the lungs, where the indurated vascularized areas surrounding caseating tubercle yielded on examination the following facts: The parallel bundles of connective tissue forming the walls of the veins were seen to be thickly invaded by the bacillus, which occurred in irregularly shaped masses, in places encroaching upon the lining membrane of the vessel, the bulging of which produced the appearance of minute tubercles, and rendered thrombosis probable. The bacilli were specially massed within the mesh-like spaces of the connective tissue forming the vessel wall. Caseation was not to be found in these structures, and the arterial walls were similarly invaded by the bacillus. It is suggested that, if the same invasion of the blood-vessels occur in the human subject, we may not have to go far to seek for an explanation of that rather inexplicable occurrence in the history of pulmonary phthisis—viz., early hæmoptysis. The vessel wall, weakened by the invasion of the micro-organism, yields before the blood-stream and gives rise to the hæmorrhage; and the discovery by Hiller of bacilli in the sputa of cases of this initial hæmoptysis seems to support the inference, which, however, should not as yet be allowed to go beyond the region of hypothesis. More plausible is the other inference which Dr. Ribbert deduces from this involvement of the veins—viz., the facility with which a general tubercular infection may arise secondarily. He is careful to point out that there is no question here of any special form of new growth in the vessel wall; but the essential feature is the presence of bacilli in situations admirably calculated to ensure their entrance into the circulation.

If these observations are verified by others, it may help to clear up the etiology of many cases of tuberculosis; the bacilli passing into the human body in our food, and then developing and multiplying.

The Treatment of Cholera.

The variety of suggestions as to the treatment of cholera, just as in all other diseases, only tends to demonstrate the unreliability of all methods. Still, as we may have a visitation, it behooves us to note them all. Dr. R. G. Jack thus writes to the *Lancet*, August 4, 1883:

"I see a good many suggestions as to the treatment of cholera in your journal, but none of them allude to what must surely prove the most effective, viz., the introduction of drugs hypodermically. I am sure the great failure in all treatment arises from the fact that all absorption is arrested, and the medicine put into the stomach is returned to the basin. The experience derived from the observation of several epidemics of cholera would induce me to rely on morphia and Fowler's solution of arsenic, diluted with twice its weight of water, and given in five-drop doses every fifteen minutes until some effect is produced. At the same time a blister may be made over the epigastrium with nitrate of silver; this I have seen do much good. Of course I would not omit the use of hot flannels and the free drinking of iced water. Having seen a great number of cases of cholera while in charge of troops between Marseilles and the Crimea, and afterwards in hospital and private practice in China, I can bear painful testimony to the small effect produced by medicines given by mouth or rectum. Arsenic in large doses I have seen do some good, as also chlorodyne, but very little."

The Results of Lithotomy.

The following paragraph occurs in the address on Surgery by Reginald Harrison, at the late meeting of the British Medical Association:

One word in reference to lithotomy before I leave the subject of stone. There is no great operation in surgery, I believe, which furnishes more successful results than this. Taking the experience of the two hospitals in this city with which I have been associated, I find there have been within my recollection 102 cases of lithotomy in persons of all ages, but chiefly in children, and operated on either by my colleagues or by myself. In only five of these cases could I ascertain that a fatal result followed. My late es-

teemed friend, and our former associate, Mr. Southam, speaking of his own experience of lithotomy at Manchester, informed me that he had operated 120 times, and could only recall one death. In the great majority of the Liverpool cases the stones were not exceedingly large, and I have no doubt that many of them might have been removed by lithotripsy. I question, however, whether the small mortality these figures indicate would thereby have been still further diminished, even if the calculation were made on a basis corresponding with the most successful statistics in lithotripsy that have hitherto been obtained.

Excessive Sweating of Hands.

For this annoying condition, Dr. F. H. Alderson says in the *Lancet*, July 28, 1883:

"The patient should soak her hands night and morning in warm water, in which should be dissolved about two drachms or half an ounce of the chloride of ammonium, and about twice as much carbonate of soda (crystals), enough water to be used to well cover the hands. I generally prescribe for my patients sufficient for six applications; and as skins vary in tenderness, tell them to use as much as will temporarily to a slight extent cause the wrinkling known as cutis aserina, a condition which I describe to them as looking like the hands of a washerwoman. After well bathing, the hands are to be well rubbed with the following embrocation: Tincture of iodine one drachm, compound camphor liniment and glycerine of each a drachm and a half, and compound liniment of belladonna one ounce. (If for the hands, a drachm of eau de Cologne makes the embrocation more agreeable.) The embrocation to be applied twice a day. A cure quickly follows. This treatment is equally appropriate and successful for excessive sweating and even bad-smelling feet, for that odor is due to the excessive function of the sudoriparous glands."

Treatment of Croup.

M. Jules Simon, of the Hôpital des Enfants Malades, treats croup as follows (*Med. Press*, July 25, 1883):

As soon as the malady is diagnosed, he touches the throat with lemon juice or a solution of muriate of iron every two hours. Every three hours he washes the part affected with a solution of borax (two drachms to the ten ounces). The atmosphere of the room is charged with atomized phenic solution, a stimulant nourishment is given, and three to five drops of tincture of iron admin-

istered every three hours. When dyspnea becomes apparent an emetic is given, but if the symptoms are not relieved, tracheotomy must be performed without delay.

The after treatment consists in placing a piece of tarlatan over the canula, warming the room, and administering beef tea and tincture of iron. The removing and cleaning of the canula should be done by an experienced person; it might be definitely removed after the eighth or tenth day. M. Simon considers that chlorate of potash is of little use in croup.

Three Cases of Removal of the Female Breast.

Mr. D'Arcy Power records these cases in the *Brit. Med. Jour.*, July 28, 1883, on account of the exceptionally rapid recoveries which occurred, and which he considered chiefly due to the position in which the patient was kept after the operation, viz., upon the side opposite to the wounded one. A free exit is thereby afforded for the discharges from the wound, through the opening left at the end of the flaps; and this opening is dependent, and is at the lowest part of the wound. The position is also convenient, as it allows of the wound being dressed with the least possible amount of disturbance to the patient. In each case the wound was syringed daily with a strong solution of Condy's fluid in water. The effect of the previous application of cold to the breast in the first case was very marked, as the hemorrhage during the operation was comparatively trifling; whereas, in the second case, where no such precaution for diminishing the quantity of blood had been taken, although the breast was small, the amount of blood lost was considerable.

The Treatment of Non-Specific Ulcers of the Leg.

Dr. Smith Baker thus writes about it in the *Med. Record*, Aug. 4, 1883:

"Hence what can be better for local treatment than to order the surface cleansed thoroughly at bedtime with a weak solution of potassium permanganate, also in the morning with a medium solution of potassium chlorate, and after having covered it lightly with absorbent cotton, to have drawn over all a well and snug-fitting elastic stocking, with instructions to go about the usual labor, using the limb freely but not senselessly? At any rate, in nine-tenths of cases, this, according to my recent experience, seems to be all-sufficient; while in the other one-tenth a few days rest and preliminary treatment with the same lotions and a pure-rubber bandage seems to be equally necessary."

Coffee in Strangulated Hernia.

In *Lyon Med.*, May 20, 1883, Dr. Sarra describes a case of strangulated femoral hernia in a man aged 63. The patient was nearly moribund; there was no appreciable radial pulse, the face was pinched, the extremities were cold, and the attempts to vomit were almost incessant. Happening to remember the report of a similar case relieved by coffee, Dr. Sarra ordered an infusion of this substance to be employed as a drink and also externally, and then took leave of the patient, warning the family that death was inevitable unless a prompt amelioration ensued. Upon returning early next morning, he was surprised to find his patient in perfect health. The man stated that soon after taking the coffee he experienced a feeling of warmth and returning strength, then a large quantity of gas was expelled above and below, and when he put his hands upon the tumor, it at once slipped back into the abdominal cavity.

Eczema of the Face.

In their work on the diagnosis and treatment of ocular affections, Messrs. Galezowski and Dague-net recommend, against the eczematous and impetiginous eruptions which often show themselves on the lids and nose of young patients suffering from phlyctenular keratitis, either calomel in powder, or the following ointment:

R. Olei cardini,	0.25 gr.
Hydrarg. oxid. rubr.,	0.10 gr.
Camphoræ,	0.25 gr.
Vaselini,	10 gr.

However, when there are many scabs, the best treatment consists in removing them with a forceps, and touching the denuded surface with a stick of nitrate of silver. The excess of caustic can be neutralized by the application of a solution of common salt.

The Formation of Callus in Diabetics.

For some years Mr. Verneuil has had this matter in his mind, and observing whenever opportunity offered, has been struck by the fact that fractures do not heal well in diabetics. From his observations, he formulates the following conclusions in *Gaz. Heb.*, July 27, 1883:

1. The retardation and absence of consolidation found in the three cases seem to be due to diabetic dyscrasia.

2. This retardation and absence of consolidation necessarily imply a diminution or suppression of the reparative forces, and particularly of nutrition.

3. From these facts we may conclude that dia-

betes, when it embarrasses or stops the formation of callus, does so, at least indirectly, by impairing nutrition.

Acute Edema of Glottis.

How dangerous and how readily provoked sometimes is this condition, is well illustrated by a case reported in the *Jour. de Med. de Bordeaux*, June 24, 1883:

A man, aged 64, previously in good health, but in whom no urinary examination was made, was suddenly seized with chills after working in the garden. The next morning there was some hoarseness and difficulty of deglutition. In the evening he was seized with a sense of suffocation. Active counter-irritation was useless, and it was decided to perform tracheotomy. The urgent symptoms subsiding, the operation was postponed; but another attack coming on, the patient died before relief could be given him.

Puncturing Bladder through Prostate.

From the address of Mr. Reginald Harrison before the *Brit. Med. Ass.* we note the following:

I may be permitted here to submit to your notice a method of puncturing the bladder through the enlarged prostate, which has afforded very gratifying results. It consists in passing the trocar through the gland, and retaining it in the perineum, so as to afford a permanent as well as a convenient drain for the urine. I should have had more diffidence in commending this operation to your notice had it not received the approval of our distinguished associate, Professor Gross, whose contributions to the surgery of the urinary organs are held in deservedly high repute on both sides of the Atlantic.

Phimosis.

While we must ever consider what might be called the radical treatment of phimosis the best, that by which the redundant prepuce is removed, yet, when high authority says otherwise, it must command our attention.

M. de St. Germain, in the *Rev. Med. France et Etrang.*, June 9, 1883, says that he believes dilatation to be the best, even in the adult. He uses Nélaton's three-bladed dilator. This procedure has always seemed to us like temporizing.

Submammary Intercostal Neuralgia.

Chiran has noticed that many women complain of this pain, which he considers due to uterine disease. In *Progrès Méd.*, June 16, 1883, he recommends the following treatment:

Tinct. gelsemium gtt. c., simple syrup, $\bar{3}$ ij., distilled water ad. $\bar{3}$ viij. S.—Dose, three to five dessertspoonfuls before meals, or three hours after. Sometimes there are extremely painful spots in the course of a nerve, and running back to the spine. These may be painted with tincture of iodine every three days.

Feeding Syphilitic Infants.

M. Parrot has introduced into the Hôpital des Enfants Assistés in Paris a nursing service for syphilitic infants. The nurslings draw their nourishment directly from the teats of the ass, to which they are presented five times during the day, and three times at night. They thrive under this treatment, and seventy per cent. live, while almost all formerly died when fed from the bottle. —*Boston Medical Journal*.

Benzoate of Sodium in Acute Gastro-intestinal Diseases.

Dr. William P. Watson claims that he has had good results from it in acute dysentery, cholera morbus, and intestinal colic. In the *Med. Record*, August 18, 1883, he publishes the following formula:

R. Sodii benzoatis,	$\bar{3}$ j.
Elixirii simplicis,	$\bar{3}$ ij.
M. S.—Two teaspoonfuls at a dose.	

Nussbaum's Treatment of Cancer.

From the *Physician and Surgeon*, we note that Professor Nussbaum has secured good results by the formation of a furrow around the tumor, down to the fascia, which he makes with the thermo-cantery. He reasons out that his success is due to the fact that the furrow prevents the feeding of the tumor by its peripheral vessels, and thus checks its growth by reducing its nourishment.

Excision of Strumous Glands.

In the *Lancet*, July 21, 1883, Dr. Henry A. Lediard relates some cases of strumous glands in which he operated as follows:

After exposing the gland, he teased away the surrounding connective tissue with two dissecting forceps, and passed a thread through the gland, which was then drawn in different directions until the gland was teased away without hemorrhage. Better results ensue when the glands are firm.

New Treatment of Phagedenic Chancre.

The non-syphilitic phagedenic chancre sometimes resists every form of treatment; excision of

the edges, cauterization and the actual cautery proving unsuccessful.

In such cases M. Thiersch, (*Gaz. Med. de Strasbourg*) has obtained a cure by the subcutaneous injection of nitrate of silver at a short distance from the borders of the ulcer. This treatment is without effect in phagedenic ulcerations of syphilitic origin.

Perosmic Acid.

M. O. Delbastaile (*Centralbl. für die Med. Wiss.*, March 31,) has met with success from the injection of a one per cent. solution of perosmic acid in sarcomata, lymphomata, strumous enlarged glands, and also cancerous glands. Three minims daily were employed. This injection had the advantage in a case of lymphoma, that, whilst it caused the shrinking of the tumor, it exerted no effect upon the surrounding textures.

Poisoning by Illuminating Gas Successfully Treated by Inhalations of Oxygen.

Dr. Alonzo Clark reports two cases in the *N. Y. Med. Jour.*, August 11, 1883; but as is usually the case in almost all reported cases of whatsoever nature, other means were resorted to. Dry cups over chest, digitalis, whisky, and hot water bottles to the extremities, were all used; and now, which proved curative, the oxygen or its accessories?

Suppositories in Piles.

The following formula is recommended in a recent issue of the *Gazette Medicale de Paris*:

R. Iodoformi,	3 j.
Balsam peru.,	3 ij.
Ol. theobromæ,	
Ceræ alb.,	ââ 3 iss.
Magnes. calcin.,	3 j. M.
Divid. in suppos. No. xij.	

One of these should be introduced after each evacuation.

Poisoning by Tartar Emetic.

In the *Brit. Med. Jour.*, July 7, 1883, Dr. Chas. Moore Jessop relates the case of a lady, who took, by mistake, at least seven and one-half and may be fifteen grains of tartar emetic. She recovered after several days' indisposition without any special treatment. The drug had been on hand for two years.

The Function of Vision.

The *Med. Record*, July 28, 1883, says:

The rods and cones in the ninth layer of the re-

tina have generally been considered to have an important function in vision. Dr. Borysikiewicz has recently asserted that they are entirely absent in the eyes of tigers and leopards which he has examined. Yet these animals have acute vision.

Intense Itching.

Dr. James Startin (*Lancet*, July 21, 1883,) recommends sponging the parts once or twice a day with pure rectified spirits, containing five minims of carbolic acid to the ounce.

Cranial Capacity of the Insane.

Dr. Amadei (*Riv. Sper. di Fren. e di Med. Leg.*) has examined 475 skulls of persons who died insane. The result of his investigations is that the cubic capacity of the cranium is greater in the insane than in the sane.

Arsenic in Certain Forms of Anæmia.

Dr. F. W. Warfvinge, of Stockholm, reports some success in the treatment of leukæmia, pseudo-leukæmia, and progressive pernicious anæmia, with arsenic, in the *Nordiskt Medicinskt Arkiv*. The dose of arsenic employed by Dr. Warfvinge was four drops of Fowler's solution given two or three times a day, and four drops of the same daily when used as an injection.

Scarlet Fever Due to a Micrococcus, and not a Bacillus.

So thinks Dr. Fraser, of Edinburgh, who formulates his views in a graduation thesis which has been specially commended by the University of Edinburgh. It does not make much difference which parasite is the cause: what we now cry out for is a parasiticide.

A Note on Vesico-Vaginal Fistulæ.

In the course of a lecture on this subject in the *Med. News*, August 18, 1883, Dr. J. Ewing Mears calls attention to the great importance of careful preliminary preparation before the operation, and lays great stress upon the use of specific remedies where the opening is due to syphilitic disease.

CORRESPONDENCE.

"Preacher-Doctors" No. 2.

EDS. MED. AND SURG. REPORTER:—

With the statement made in the article of your last issue under the above heading that "it is not within the intellectual capacity of any man to successfully and practically follow any two or more of the learned professions, neither I, nor perhaps any of your readers, can have any disagreement; but with what seems to me to be the spirit underlying the

article, the spirit of uncharitable opposition, issue should be taken, at least so far as to a proper discrimination as to the application of the diatribes.

Let me quote a few of the epithets: "Diabolical Frauds," "Spiritual Mountebanks," "Half-and-Half Rascals." And he characterizes them as specimens of hybridity, exercising a "diabolical diplomacy," as well as tricks, schemes, etc.

Now, we think this is rather straining a point, for while occasionally there may be one who "invades the sanctuary in a hypocritical spirit, and simply uses the pulpit as an advertising medium," it would manifestly be as unjust to judge all preacher-doctors by them, as to condemn all specialists (doctors) because some set themselves up as oculists, or surgeons, or professors, who are lamentably ignorant of their specialty—perhaps hoping thereby to gain a general practice; or to condemn all medical lecturers because one may seek to make himself a sort of reputation by inveighing against a class of his own marking-out.

We have as hearty a contempt for a hypocrite as any man; but to declare a man a hypocrite *without the most positive proof* "is to invade the realm of the motives which none but the Infinite may do" without presumption.

The simple fact that a man both preaches and practices, is not evidence of hypocrisy. It is evident that if he habitually does both, he can be as efficient in neither as he would be in either alone; but if he be in truth a "man of God who walks in the footsteps of his Divine Master with a contrite, humble heart," and seeks to know His will and understand the Scriptures, his general abilities may qualify him to teach (preach) even without "constant meditation;" and certainly the possession of such a spirit will lead him in such teaching to seek only "the conversion of souls, or the edification of believers." He may not have felt "called of God" for the especial work of the ministry; but having been called into the vineyard, he may be willing to labor outside his special line if the skilled laborer be wanting. Such men are not frauds, or mountebanks; and it is because there was no room in "A Regular Subscriber's" article for such exceptions as these—and they are doubtless the rule, rather than the exception—that this article has been written. While we admit that there are frauds and frauds, let "Regular Subscriber" and his pattern, Dr. Knight, and others of like inclinations, be cautious in such assertions as that a patient died under the treatment of a physician who preached, who would doubtless have recovered if treated by one who did not preach, i. e., one who gives his undivided attention to his profession—for even such sometimes lose patients.

Now, we are not one of the preacher-doctors, but to us it would seem as unjust to condemn this class so sweepingly as it would to condemn a doctor who, besides his profession, makes for himself a name as a scientific investigator in some other line. Let us have opinion based on judgment rather than on prejudice. ANOTHER SUBSCRIBER.

—The *Deutsch. Med. Woch.*, June 13, 1883, contains a report of the removal of a kidney for pyonephrosis; the patient, a young woman, died on the fourteenth day.

FOREIGN CORRESPONDENCE.

British Medical Association.

EDS. MED. AND SURG. REPORTER:—

I thought a few remarks on the above subject would be acceptable for your journal. We arrived in Liverpool as delegates to the British Medical Association. Its central position and the scientific eminence and hospitality of the profession was sufficient to guarantee the success of the meeting. The local organization was perfect, especially the Reception Committee, the Secretary of which (Dr. Rich) was extremely courteous to us. The arrangement is something after the same manner as the American Medical Association. We arrived too late to listen to the address of the President. The address in "Surgery," by Mr. Reginald Harrison, contained many practical points and was full of interest. In connection with urethral surgery, he showed though the art of surgery was an imperfect one, it was a progressive one. The address on "Pathology," by Dr. Creighton, contained very much valuable information on bacterial pathology. Bovine tubercle, small-pox, yellow fever, and contagious ophthalmia, were considered.

We found the same fault in the "sections" of the British Medical Association as we do in the American Medical Association, to wit: too many papers read, and very little discussion. Everything seems, to use an American expression, to be "railroaded through;" but on the whole, the meeting was a success.

DR. H. ISAAC JONES, of Scranton, Pa.
Tremadoc, North Wales, August 21, 1883.

NEWS AND MISCELLANY.

M. Pasteur on the Etiology of Cholera.

The Paris correspondent of the *Lancet* says:

M. Pasteur having been solicited to lay before the public the instructions he had given the members of the scientific mission to Egypt to investigate the nature of cholera, now raging in that country, and which was noticed in your annotation of last week, has generously complied with the expressed desire of his friends. M. Pasteur prefaced his instructions (of which I send you an abstract copy) by remarking that the precautions hereinafter enumerated relate to those cases where the causes of contagion will be found to prevail in their maximum intensity. These precautions, he added, are instituted under the hypothesis, which he considers very probable, if not certain, that cholera does not enter the human organism by the air passages, but that it does so only by the digestive canal, unless under very exceptional circumstances:

1. Not to make use of the drinking-water of the locality in which the mission will be located without having previously boiled the water, and shaken it well, after it has become cold, for two or three minutes, in a bottle half filled; or the water may be put into vessels previously heated, "vases flambé"—that is to say, vessels that had been subjected to air heated to about 150° C., or even more; the higher the temperature the better. The natural mineral waters may be employed with advantage instead.

2. Make use of wine that has been heated in bottles to from 55° to 60° C., and which should be drunk in glasses also previously heated.

3. To make use of alimentary substances only after being well cooked, and fruits in their natural state, but previously washed with water that had been boiled, and preserved in the same vessels in which it was boiled, or had been transferred into those previously heated.

4. To make use of bread cut up into thin slices and submitted to a temperature of about 150° C., during twenty minutes or more.

5. All the vessels employed for alimentary purposes should also be previously subjected to a temperature of 150° C., or more.

6. The bed linen and towels should be plunged into boiling water, and then dried.

7. The water for washing or bathing should be previously boiled, and, after being cooled, mixed with solutions of thymic or of carbolic acid, the former in the proportion of 1 to 500 parts, and the latter 1 to 50 parts.

8. The hands and face should be washed frequently during the day with boiled water, and to which should be added solutions of thymic and carbolic acid.

9. It is only in cases where the bodies of patients who have died from cholera or their soiled linen has to be handled that it would be necessary to cover the mouth and nostrils with a small mask formed of two pieces of thin plates of metal, enclosing between them a little cotton-wool of not more than 1 centimetre thick, the mask having been submitted to 150° C. only, and renewing the temperature of 150° on each fresh exposure to contagion.

On Personal Precautions that may be Adopted by Medical Men whilst Attending Cases of Infectious Disease.

Dr. Charles Green makes these suggestions in the *Lancet*:

1. Always have the window opened before entering the patient's room or ward.

2. Never stand between the patient and the fire, but always between him and the open window.

3. If possible, change your coat before entering the room.

4. Do not go in for unnecessary auscultation or other physical examination.

5. Stay as short a time as possible in the room.

6. Never, while in the room, swallow any saliva.

7. After leaving the sick room, wash the hands with water containing an antiseptic.

8. Rinse out the mouth with diluted "toilet Sanitas" or Condy's fluid, also gargle the throat with it, and bathe the eyes, mouth, and nostrils.

9. Expectorate and blow the nose immediately on leaving the sick-room.

10. Keep up the general health by good food, exercise, and temperance.

11. In addition to the above recommendations, which are all pretty generally known, I would suggest another, which is, in my opinion, the most important of all. This is to filter all the air you breathe while in the sick-room or ward through an antiseptic medium. My method is to use a McKenzie's inhaler over the nose and mouth.

I carefully soak the sponge in a strong solution of carbolic acid before entering the sick-room. It is so made that all the air breathed must necessarily come through this sponge, and the expired air is emitted by a valve action at another place. I have worn this not only in the Fever Hospital wards, but in many of the typhus dens in this borough. It is to this method that I attribute the fact that although I have attended between 200 and 300 cases of typhus during the last twelve months, and seen many more, I have hitherto escaped infection myself. The only objection (which is not of much importance in a hospital) is the unsightly appearance one has with the inhaler *in situ*. This objection, is, however, a very slight one when weighed against the greatly increased safety one not only feels, but I believe actually possesses. I am not aware of this method having been mentioned previously; and this fact, and my desire to prevent a repetition of the late disastrous fatalities, must be my apology for bringing it before the profession.

The Prevention of Calculous Disease.

In the course of Mr. Reginald Harrison's address before the late meeting of the British Medical Association, occurs the following paragraph:

"Considering the great activity that has within recent years been shown in demonstrating the preventable nature of many diseases, and the energy that has been displayed in grappling with them, it seems remarkable that no adequate steps should have been taken to ameliorate the hygienic condition of certain parts of this country where the amount of calculous disease is excessive, and the inhabitants, consequently, are exposed to an inordinate risk of contracting it. The admirable address by Mr. Cadge before our Association at Norwich, in 1874, furnishes abundant data for the further prosecution of inquiries of this kind. I cannot help thinking that if it could be shown to be even probable that the dogs, cats, rabbits, or frogs of the aforesaid districts were inconvenienced in a like manner with their owners, the matter would long ago have been forced upon our legislature with all the exaggeration that usually characterizes agitations of this kind."

Another Prize.

The Grocers' Company of London offers a prize of \$5,000 open to universal competition, to the discoverer of a method by which vaccine may be cultivated in an indifferent medium. The process must allow of the indefinite multiplication of the virus by successive generations, and the product of each generation must have the properties of natural vaccine lymph, so far as the time allowed may suffice to determine. A description of the process, written in English, must be submitted before December 31, 1886, and the prize will be awarded as soon after that date as possible. Further information may be had by addressing the clerk of the Grocers' Company, Grocers' Hall, London.

The Origin of the Cholera Epidemic.

A very interesting report has been published by Chaffey Bey as the origin of the outbreak at Damietta. After a careful analysis of all the circumstances of the case, he arrived at the con-

elusion that the cholera was not imported, but broke out spontaneously on account of the condition of the river and city, which this year presented conditions similar to those to be found on the banks of the Ganges when the epidemic made its appearance. The great fair at Damietta attracted a crowd of fifteen thousand people, who for eight days lived on foul water and decayed fish.

Women Doctors for India.

The project for introducing medical women into Bombay is now fairly established, upwards of 40,000 rupees having been already subscribed for this purpose. The *Hindoo Patriot* states that the scheme includes the bringing out of women doctors from England; the establishment of a dispensary for the poor; medical education for female students, through the Grant Medical College; and, finally, the establishment of a hospital for women and children. A Parsee has offered a lakh of rupees to build a hospital of the latter description.

A Righteous Judgment.

Lacombe, the French wholesale druggist, who was accused of fraudulently substituting sulphate of cinchonidine for sulphate of quinine, which he supplied to the Paris hospitals last autumn, has been sentenced to a year's imprisonment and 50 francs penalty, and is also called upon to pay for the advertisement of the judgment in a dozen French journals.

Personal.

—R. Dorsey Coale, Ph. D., Assistant in Chemistry, Johns Hopkins University, has been appointed Lecturer on Chemistry in the School of Medicine of the University of Maryland.

—The following gentlemen have been appointed by the Governor the State Board of Health of Missouri: E. H. Gregory, W. R. Conery, and P. D. Yost, of St. Louis; G. M. Cox, of Springfield; G. T. Bartlett, of Poplar Bluffs; H. F. Hereford, of Kansas City; and S. C. Hearne, of Hannibal.

—Dr. Donald McLean, of Ann Arbor, has been appointed Surgeon-in-Chief of the Michigan Central System of Railroads.

—Dr. W. E. Quine, late of the Chicago Medical College, has been elected to the Chair of Practice of Medicine in the College of Physicians and Surgeons of Chicago.

—Dr. Spina, Koch's opponent, has been nominated Professor of General and Experimental Pathology at Prague.

—Dr. Holmes will deliver the address at the opening of the new building of the Harvard Medical School, October 15.

—Dr. Shoshee Bhoosur Mookes Gee is the name of the President of a new Homoeopathic Medical College recently founded in Calcutta, India.

Items.

—The *Glasgow Medical Journal* for August, 1883, contains the report of a successful hip-joint amputation.

—The English surgeons who volunteered for service in Egypt during the cholera epidemic, are paid \$500 per month.

—M. De Lacaille, of Rio de Janeiro, reports successful treatment of yellow fever with carbolic acid and carbolate of ammonia.

—In the *Lancet*, July 21, 1883, is reported a severe case of compound comminuted fracture of skull with recovery, and also a case of depressed and comminuted fracture of skull with recovery.

—According to the *Deutsche Medizinische Zeitung*, the widow of Professor Boll, who is a daughter of Traube, has been made a doctor of medicine in Rome.

—The Egyptian census returns have just been completed, and show that the population of the country comprises 3,393,918 males, and 3,404,312 females.

—Professor H. Newell Martin, of the Johns Hopkins University, Baltimore, has been appointed the next Croonian lecturer of the Royal Society of London.

—Professor Osler, of McGill University, Montreal, says the *Canada Medical Record*, has been elected a Fellow of the Royal College of Physicians of London.

—The British Medical Association object to the compulsory notification of infectious diseases by the physician, preferring to have this obligation placed upon the householder.

—The Brunton Memorial Prize of the University of Glasgow, given to the most distinguished graduate in medicine of the year, has been won this year by John Innes Dunlop, M. B., C. M.

—The *Pittsburgh Medical Journal* states that a charter has been obtained for an institution to be termed the Pittsburgh Medical College, but adds that preparations have not been completed for its organization.

—Dr. Thomas Dwight has been appointed to the chair of anatomy at Harvard, the duties of which he has discharged during the past winter on account of the resignation of Dr. Oliver Wendell Holmes.

—The *Journal of Psychological Medicine and Mental Pathology* has ceased its publication. It is one of the old journals connected with the last generation, and was first issued under the editorship of the late Dr. Forbes Winslow, Sr.

—In the course of a dispute between the Chicago dealers in lard, it has been incidentally disclosed that most American lard is adulterated from ten to one hundred per cent. with oleomargarine, stearine, cotton-seed oil, tallow, and terra alba.—*Boston M. and S. Jour.*, Aug. 2, 1883.

—At a meeting of the trustees of the Astley Cooper Prize Fund, held at Guy's Hospital, on July 20, the triennial prize of \$1,500 was awarded to Dr. William Alexander, of Liverpool. The subject of the essay was "The Pathology and Pathological relations of the Disease known as Osteo-Arthritis, or Chronic Rheumatic Arthritis."

—In the *Lancet*, August 4, 1883, Mr. Pick reports a case of suture of the musculo-spiral nerve six months after its complete division, with entire restoration of its functions about one year after operation; and in the same journal Dr. Noble Smith reports a case of spina bifida successfully treated by injection and examined *post mortem*.